

DIZZINESS HANDICAP INVENTORY

Patient Name _____

Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

- 1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 but < 4 per month (3) more than one per week
- 2. My dizziness/unsteadiness is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness/unsteadiness. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your dizziness/unsteadiness only.

YES SOMETIMES NO

- | | | | | |
|-------|-------|-------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| _____ | _____ | _____ | P1. | Does looking up increase your problem? |
| _____ | _____ | _____ | E2. | Because of your problem, do you feel frustrated? |
| _____ | _____ | _____ | F3. | Because of your problem, do you restrict your travel for business or recreation? |
| _____ | _____ | _____ | P4. | Does walking down the aisle of a supermarket increase your problem? |
| _____ | _____ | _____ | F5. | Because of your problem, do you have difficulty getting into or out of bed? |
| _____ | _____ | _____ | F6. | Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? |
| _____ | _____ | _____ | F7. | Because of your problem, do you have difficulty reading? |
| _____ | _____ | _____ | P8. | Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? |
| _____ | _____ | _____ | E9. | Because of your problem, are you afraid to leave your home without someone accompanying you? |
| _____ | _____ | _____ | E10. | Because of your problem, have you been embarrassed in front of others? |
| _____ | _____ | _____ | P11. | Do quick movements of your head increase your problem? |
| _____ | _____ | _____ | F12. | Because of your problem, do you avoid heights? |
| _____ | _____ | _____ | P13. | Does turning over in bed increase your problem? |
| _____ | _____ | _____ | F14. | Because of your problem, is it difficult for you to do strenuous house work or yard work? |
| _____ | _____ | _____ | E15. | Because of your problem, are you afraid people may think you are intoxicated? |
| _____ | _____ | _____ | F16. | Because of your problem, is it difficult for you to go for a walk by yourself? |
| _____ | _____ | _____ | P17. | Does walking down a sidewalk increase your problem? |
| _____ | _____ | _____ | E18. | Because of your problem, is it difficult for you to concentrate? |
| _____ | _____ | _____ | F19. | Because of your problem, is it difficult for you to walk around your house in the dark? |
| _____ | _____ | _____ | E20. | Because of your problem, are you afraid to stay home alone? |
| _____ | _____ | _____ | E21. | Because of your problem, do you feel handicapped? |
| _____ | _____ | _____ | E22. | Has your problem placed stress on your relationships with members of your family or friends? |
| _____ | _____ | _____ | E23. | Because of your problem, are you depressed? |
| _____ | _____ | _____ | F24. | Does your problem interfere with your job or household responsibilities? |
| _____ | _____ | _____ | P25. | Does bending over increase your problem? |

_____ Examiner

OTHER COMMENTS: _____

With Permission from: Jacobson GP, Newman CW. The development of the dizziness handicap inventory. *Arch Otolaryngol Head Neck Surg* 1990;116:424-427, Copyrighted 1990, American Medical Association.