

Dizziness Handicap Inventory

Name: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check “always”, or “never” or “sometimes” to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	Never
F1	Because of your problem, do you restrict your travel for business or pleasure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2	Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F3	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4	Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F5	Does performing more ambitious activities like sports, dancing, and household chores (such as sweeping or putting dishes away) increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F6	Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7	Because of your problem, is it difficult for you to do strenuous house work or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F8	Because of your problem, is it difficult for you to go on a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F9	Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F10	Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11	Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12	Because of your problem, are you afraid of leaving your home without being accompanied?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E13	Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14	Because of your problem, are you afraid people may think that you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E15	Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E16	Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E17	Has your problem placed stress on your relationship with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E18	Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E19	Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P20	Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P21	Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P22	Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P23	Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P24	Does walking down the sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P25	Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

KEY: Always= 4 Sometimes= 2 Never=0

Total Score: _____