# Dizziness Handicap Inventory Questionnaire

Name: _____DOB:_____ Date:_____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer “yes”, “no” or “some” (sometimes affected) to each question. *Answer as it applies to your dizziness or unsteadiness only.*

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| | Does looking up increase your problem? | Yes | Some | No |
| | Because of your problem, do you feel frustrated? | Yes | Some | No |
| | Because of you problem, do you restrict your travel for business or recreation? | Yes | Some | No |
| | Does walking down the aisle of a supermarket increase your problem? | Yes | Some | No |
| | Because of your problem, do you have difficulty getting into or out of bed? | Yes | Some | No |
| | Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or to parties? | Yes | Some | No |
| | Because of your problem, do you have difficulty reading? | Yes | Some | No |
| | Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? | Yes | Some | No |
| | Because of your problem, are you afraid to leave your home without someone accompanying you? | Yes | Some | No |
| | Because of your problem, have you been embarrassed in front of others? | Yes | Some | No |
| | Do quick movements of your head increase your problem? | Yes | Some | No |
| | Because of your problem, do you avoid heights? | Yes | Some | No |
| | Does turning over in bed increase your problem? | Yes | Some | No |
| | Because of your problem, is it difficult for you to do strenuous housework or yard work? | Yes | Some | No |
| | Because of your problem, are you afraid people may think you are intoxicated? | Yes | Some | No |
| | Because of your problem, is it difficult for you to go for a walk by yourself? | Yes | Some | No |
| | Does walking down a sidewalk increase your problem? | Yes | Some | No |
| | Because of your problem, is it difficult for you to concentrate? | Yes | Some | No |
| | Because of your problem, is it difficult for you to walk around your house in the dark? | Yes | Some | No |
| | Because of your problem, are you afraid to stay home alone? | Yes | Some | No |
| | Because of your problem, do you feel handicapped? | Yes | Some | No |
| | Has your problem placed stress on you relationships with members of your family or friends? | Yes | Some | No |
| | Because of your problem, are you depressed? | Yes | Some | No |
| | Does your problem interfere with your job or household responsibilities? | Yes | Some | No |
| | Does bending over increase your problem? | Yes | Some | No |