DIZZINESS HANDICAP INVENTORY

Name: _____Date:_____

Part I

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by circling "yes or "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

P1. Does looking up increase your problem?	Yes	No	Sometimes
E2. Because of your problem, do you feel frustrated?	Yes	No	Sometimes
F3. Because of your problem, do you restrict your travel for business or recreation?	Yes	No	Sometimes
P4. Does walking down the aisle of a supermarket increase your problem?	Yes	No	Sometimes
F5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	No	Sometimes
F6. 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	No	Sometimes
F7. Because of your problem, do you have difficulty reading?	Yes	No	Sometimes
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes	No	Sometimes
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	Yes	No	Sometimes
E10. Because of your problem, have you been embarrassed in front of others	Yes	No	Sometimes
P11. Do quick movements of your head increase your problem?	Yes	No	Sometimes
F12. Because of your problem, do you avoid heights?	Yes	No	Sometimes
P13. Does turning over in bed increase your problem?	Yes	No	Sometimes

F14. Because of your problem, is it difficult for you to do strenuous housework or yard work? Yes No Sometimes

E15. Because of your problem, are you afraid people might think you are intoxicated? Yes No Sometimes

F16. Because of your problem, is it difficult for you to go for a walk by yourself? Yes No Sometimes

P17. Does walking down a sidewalk increase your problem? Yes No Sometimes

E18. Because of your problem, is it difficult for you to concentrate? Yes No Sometimes

F19. Because of your problem, is it difficult for you walk around the house in the dark? Yes No Sometimes

E20. Because of your problem, are you afraid to stay home alone? Yes No Sometimes

E21. Because of your problem, do you feel handicapped? Yes No Sometimes

E22. Has your problem placed stress on your relationships with Members of your family or friends? Yes No Sometimes

E23. Because of your problem, are you depressed? Yes No Sometimes

F24. Does your problem interfere with your job or household responsibilities? Yes No Sometimes

P25. Does bending over increase your problem? Yes No Sometimes