Patient Name: ____________________________________ DOB: _________ Date: ___________

The Dizziness Handicap Inventory (DHI)

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 "sometimes" to each question. Answer as it applies to your dizziness or unsteadiness only.

#	Question						
1	Does looking up increase your problem?		NO		Sometimes		Yes
2	Because of your problem, do you feel frustrated?		NO		Sometimes		Yes
3	Because of you problem, do you restrict your travel for business or recreation?		NO		Sometimes		Yes
4	Does walking down the aisle of a supermarket increase your problem?		NO		Sometimes		Yes
5	Because of your problem, do you have difficulty getting into or out of bed?		NO		Sometimes		Yes
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing or to parties?		NO		Sometimes		Yes
7	Because of your problem, do you have difficulty reading?		NO		Sometimes		Yes
8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?		NO		Sometimes		Yes
9	Because of your problem, are you afraid to leave your home without someone accompanying you?		NO		Sometimes		Yes
10	Because of your problem, have you been embarrassed in front of others?		NO		Sometimes		Yes
11	Do quick movements of your head increase your problem?		NO		Sometimes		Yes
12	Because of your problem, do you avoid heights?		NO		Sometimes		Yes
13	Does turning over in bed increase your problem?		NO		Sometimes		Yes
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?		NO		Sometimes		Yes
15	Because of your problem, are you afraid people may think you are intoxicated?		NO		Sometimes		Yes
16	Because of your problem, is it difficult for you to walk by yourself?		NO		Sometimes		Yes
17	Does walking down a sidewalk increase your problem?		NO		Sometimes		Yes
18	Because of your problem, is it difficult for you to concentrate?		NO		Sometimes		Yes
19	Because of your problem, is it difficult for you to walk around your house in the dark?		NO		Sometimes		Yes
20	Because of your problem, are you afraid to stay home alone?		NO		Sometimes		Yes
21	Because of your problem, do you feel handicapped?		NO		Sometimes		Yes
22	Has your problem placed stress on you relationships with members of your family or friends?		NO		Sometimes		Yes
23	Because of your problem, are you depressed?		NO		Sometimes		Yes
24	Does your problem interfere with your job or household responsibilities?		NO		Sometimes		Yes
25	Does bending over increase your problem?		NO		Sometimes		Yes

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