Dizziness Handicap Inventory

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 each question as it pertains to your dizziness or unsteadiness problem only.*

ITEM	RESPONSE
1. Does looking up increase your problem?	_____
2. Because of your problem, do you feel frustrated?	_____
3. Because of your problem, do you restrict your travel for business or recreation?	_____
4. Does walking down the aisle of a supermarket increase your problem?	_____
5. Because of your problem, do you have difficulty getting into or out of bed?	_____
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?	_____
7. Because of your problem, do you have difficulty reading?	_____
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	_____
9. Because of your problem, are you afraid to leave your home without having someone accompany you?	_____
10. Because of your problem, have you been embarrassed in front of others?	_____
11. Do quick movements of your head increase your problem?	_____
12. Because of your problem, do you avoid heights?	_____
13. Does turning over in bed increase your problem?	_____
14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?	_____
15. Because of your problem, are you afraid people may think you are intoxicated?	_____
16. Because of your problem, is it difficult for you to go for a walk by yourself?	_____
17. Does walking down a sidewalk increase your problem?	_____
18. Because of your problem, is it difficult for you to concentrate?	_____
19. Because of your problem, is it difficult for you to walk around your house in the dark?	_____
20. Because of your problem, are you afraid to stay home alone?	_____
21. Because of your problem, do you feel handicapped?	_____
22. Has your problem placed stress on your relationships with members of your family or friends?	_____
23. Because of your problem, are you depressed?	_____
24. Does your problem interfere with your job or household responsibilities?	_____
25. Does bending over increase your problem?	_____

Reprinted with permission. Jacobson GP, Newman CW. The Development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990; 116:424-427.

DIZZINESS QUESTIONNAIRE

Name: _____ Date: _____
Age: _____

Please answer all questions to the best of your ability. *Please give the necessary details for yes answers.*

Exactly when and how did your problems begin?

_____
_____
_____
_____
_____

Was there a specific initial cause?

_____
_____
_____
_____

Please describe your symptoms in detail.

_____
_____
_____
_____

1. Rate the level of your dizziness at the *present moment.*

0	1	2	3	4	5	6	7	8	9	10
no dizziness										very intense dizziness

2. In general, how much does your dizziness interfere with your day-to-day activities?

0	1	2	3	4	5	6	7	8	9	10
no interference										extreme interference

3. Since the time your dizziness began, how much has dizziness changed your ability to work?
(____Check here if retired for reasons unrelated to your dizziness.)

0	1	2	3	4	5	6	7	8	9	10
no change										extreme change

4. On the average, how has your dizziness been during the *last week?*

0	1	2	3	4	5	6	7	8	9	10
not at all severe										extremely severe

5. How much do you limit your activities to keep your dizziness from getting worse?

0	1	2	3	4	5	6	7	8	9	10
not at all										very much

6. On an average day, how much does your dizziness vary (increase or decrease)?

0	1	2	3	4	5	6	7	8	9	10
remains the same										changes a lot

7. How often are you able to do something that helps to reduce dizziness?

0	1	2	3	4	5	6	7	8	9	10
never										very often

Please make any additional comments you feel would be helpful:

_____
_____
_____
_____