Adventist Health

Dizziness Handicap Inventory Questionnaire

Name: _____ Date: ____/____ /_____Score: _____

Date: ___/ _____/_____Score: _____

Please circle the most appropriate answer for each question as it pertains to your dizziness or unsteadiness problem only.

P1	Does looking up increase your problem?	Yes	Sometimes	No
E2	Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F3	Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P4	Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
P5	Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F6	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, going to parties, or dancing?	Yes	Sometimes	No
F7	Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P8	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
E9	Because of your problem, are you afraid to leave your home without someone accompanying you?	Yes	Sometimes	No
E10	Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No

P11	Do quick movements of your head increase your problem?	Yes	Sometimes	No
F12	Because of your problem, do you avoid heights?	Yes	Sometimes	No
F13	Does turning over in bed increase your problem?	Yes	Sometimes	No
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E15	Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P17	Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E18	Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	Yes	Sometimes	No
E20	Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E21	Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E22	Has your problem placed stress on your relationships with members or your family or friends?	Yes	Sometimes	No
E23	Because of your problem, are you depressed?	Yes	Sometimes	No
F24	Does your problem interfere with your job or household responsibilities	Yes	Sometimes	No
P25	Does bending over increase your problem?	Yes	Sometimes	No