

EASTERN VIRGINIA MEDICAL SCHOOL
 Department of Otolaryngology-Head and Neck Surgery
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NAME _____ MR # _____
 Referred By _____ Age _____ Date _____

DIZZINESS HANDICAP INVENTORY (DHI)

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check one answer to each question, and answer each question as it pertains to you dizziness problem only.

	YES	SOMETIMES	NO
P1. Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4. Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P8. Do more ambitious activities, such as sports and dancing, and household chores like sweeping or putting away dishes increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P11. Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P13. Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P17. Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P25. Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subtotal:	_____		
E2. Because of your problem, do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. Because of your problem, have you felt embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E15. Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIZZINESS HANDICAP INVENTORY (DHI) - continued

	<u>YES</u>	<u>SOMETIMES</u>	<u>NO</u>
E18. Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E21. Because of your problem, do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. Has your problem placed stress on your relationships with family member or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. Because of your problem, are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subtotal	_____		
F3. Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F5. Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, movies, dancing, or parties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of your problem, do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F12. Because of your problem, do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F14. Because of your problem, is it difficult for you to do strenuous house or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. Because of your problem, is it difficult for you to Walk around your house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subtotal	_____		
TOTAL	_____		