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DHI (Dizziness Handicap Index)

Instructions: The purpose of this questionnaire 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 problem only.

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

Yes (4) Sometimes (2) No (0)

Signature _____Date_____