

## Dizziness Handicap Inventory (DHI)

|               |       |
|---------------|-------|
| Patient Name: | Date: |
|---------------|-------|

**Instructions:**

- **The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness.**
- **Please check “Yes”, “Sometimes”, or “No” to each question.**
- **Answer each question as it pertains to your dizziness or unsteadiness problem only.**

|   | Yes | Sometimes | No |
|---|-----|-----------|----|
| 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 or dancing or household chores such as sweeping or putting the dishes away increase the problem?     |     |           |    |
| 9. Because of your problem, are you afraid of leaving your home without someone accompanying you?   |     |           |    |
| 10. Because of your problem, are you 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 at home?                                |  |  |  |
| 21. Because of your problem, do you feel handicapped?                                       |  |  |  |
| 22. Has your problem placed stress on your relationships with 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?  |  |  |  |