

NAME: _____ DATE: _____

DOB: _____

DIZZINESS HANDICAP INVENTORY

	<u>YES</u>	<u>SOMETIMES</u>	<u>NO</u>
1. Does looking up increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Because of your problem do you feel frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Because of your problem do you restrict your travel for business or recreation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Because of your problems do you have difficulty getting into or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. 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"/>
7. Because of your problem do you have difficulty reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting dishes away increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Because of your problems are you afraid to leave your home without having someone accompany you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Because of your problems have you been embarrassed in front of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do quick movements of your head increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Because of your problem do you avoid heights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does turning over in bed increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Because of your problem is it difficult for you to do strenuous housework or yardwork?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Because of your problem are you afraid people may think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. 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"/>
17. Does walking down a sidewalk increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Because of your problem is it difficult for you to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. 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"/>
20. Because of your problems are you afraid to stay home alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Because of your problem do you feel handicapped?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has your problem placed stress on your relationships with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Because of your problem are you depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Does bending over increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>