



**Hearing & Balance Center
Dizziness Handicap Index**

Name: _____ Date: _____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "No", or "Sometimes" to each question by writing the corresponding letter in the blanks on the right side of the paper. *Answer each question as it pertains to your dizziness or unsteadiness only.*

	Yes, No, or Sometimes	For internal use only.		
		P	E	F
1. Does looking up increase your problem?	_____	<input type="checkbox"/>		
2. Because of your problem, do you feel frustrated?	_____		<input type="checkbox"/>	
3. Because of your problem, do you restrict your travel for business or recreation?	_____			<input type="checkbox"/>
4. Does walking down the aisle of a supermarket increase your problem?	_____	<input type="checkbox"/>		
5. Because of your problem, do you have difficulty getting into or out of bed?	_____			<input type="checkbox"/>
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	_____			<input type="checkbox"/>
7. Because of your problem, do you have difficulty reading?	_____			<input type="checkbox"/>
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	_____	<input type="checkbox"/>		
9. Because of your problem, are you afraid to leave your home without having some one accompany you?	_____		<input type="checkbox"/>	
10. Because of your problem, have you been embarrassed in front of others?	_____		<input type="checkbox"/>	
11. Do quick movements of your head increase your problem?	_____	<input type="checkbox"/>		
12. Because of your problem, do you avoid heights?	_____			<input type="checkbox"/>
13. Does turning over in bed increase your problem?	_____	<input type="checkbox"/>		
14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?	_____			<input type="checkbox"/>
15. Because of your problem, are you afraid people may think you are intoxicated?	_____		<input type="checkbox"/>	
16. Because of your problem, is it difficult for you to walk by yourself?	_____			<input type="checkbox"/>
17. Does walking down a sidewalk increase your problem?	_____	<input type="checkbox"/>		
18. Because of your problem, is it difficult for you to concentrate?	_____		<input type="checkbox"/>	
19. Because of your problem, is it difficult for you to walk around your house in the dark?	_____			<input type="checkbox"/>
20. Because of your problem, are you afraid to stay home alone?	_____		<input type="checkbox"/>	
21. Because of your problem, do you feel handicapped?	_____		<input type="checkbox"/>	
22. Has your problem placed stress on your relationships with members of your family or friends?	_____		<input type="checkbox"/>	
23. Because of your problem, are you depressed?	_____		<input type="checkbox"/>	
24. Does your problem interfere with your job or household responsibilities?	_____			<input type="checkbox"/>
25. Does bending over increase your problem?	_____	<input type="checkbox"/>		
Total		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL	_____			