UNIVERSITY OF THE
PACIFIC
HEARING & BALANCE CENTER

Dizziness Handicap Inventory

Patient Name _____ Date _____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

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 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 home without having someone with 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 yard work?	☐ Yes ☐ Sometimes ☐ No
15.	Because of your problem, are you afraid people may think 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 go for a 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 relationship with members of your family or 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

DHI Score _____

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