### The Dizziness Handicap Inventory (DHI)

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<tbody>
<tr>
<td>P1. Does looking up increase your problem?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>E2. Because of your problem, do you feel frustrated?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>F3. Because of your problem, do you restrict your travel for business or recreation?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<td>P4. Does walking down the aisle of a supermarket increase your problems?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<td>F5. Because of your problem, do you have difficulty getting into or out of bed?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<td>F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<td>F7. Because of your problem, do you have difficulty reading?</td>
<td>o Yes</td>
<td>o Sometimes</td>
</tr>
<tr>
<td>P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>E9. Because of your problem, are you afraid to leave your home without having someone accompany you?</td>
<td>o Yes</td>
<td>o Sometimes</td>
</tr>
<tr>
<td>E10. Because of your problem have you been embarrassed in front of others?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>P11. Do quick movements of your head increase your problem?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<td>F12. Because of your problem, do you avoid heights?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>P13. Does turning over in bed increase your problem?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?</td>
<td>o Yes</td>
<td>o Sometimes</td>
</tr>
<tr>
<td>E15. Because of your problem, are you afraid people may think you are intoxicated?</td>
<td>o Yes</td>
<td>o Sometimes</td>
</tr>
<tr>
<td>F16. Because of your problem, is it difficult for you to go for a walk by yourself?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>P17. Does walking down a sidewalk increase your problem?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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<tr>
<td>E18. Because of your problem, is it difficult for you to concentrate</td>
<td>o Yes</td>
<td>o Sometimes</td>
</tr>
<tr>
<td>F19. Because of your problem, is it difficult for you to walk around your house in the dark?</td>
<td>o Yes</td>
<td>o Sometimes</td>
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**DHI Scoring Instructions**

The patient is asked to answer each question as it pertains to dizziness or unsteadiness problems, specifically considering their condition during the last month. Questions are designed to incorporate functional (F), physical (P), and emotional (E) impacts on disability.

To each item, the following scores can be assigned:

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<th>No</th>
<th>Sometimes</th>
<th>Yes</th>
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Scores:
Scores greater than 10 points should be referred to balance specialists for further evaluation.

16-34 Points (mild handicap)
36-52 Points (moderate handicap)
54+ Points (severe handicap)

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**E20.** Because of your problem, are you afraid to stay home alone?
- o Yes
- o Sometimes
- o No

**E21.** Because of your problem, do you feel handicapped?
- o Yes
- o Sometimes
- o No

**E22.** Has the problem placed stress on your relationships with members of your family or friends?
- o Yes
- o Sometimes
- o No

**E23.** Because of your problem, are you depressed?
- o Yes
- o Sometimes
- o No

**F24.** Does your problem interfere with your job or household responsibilities?
- o Yes
- o Sometimes
- o No

**F25.** Does bending over increase your problem?
- o Yes
- o Sometimes
- o No

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Used with permission from GP Jacobson.
**Vestibular Questionnaire:**

Patient: ______________________ Date: ____________

**Characterize your dizziness:**

1. Light-headedness, faintness, giddiness.
2. Unsteadiness, imbalance
3. Objects are spinning around you and you are still.
4. You are spinning around and objects around you are still.
5. You blackout or lose consciousness
6. Tendency to fall. Please circle the direction (s)
   - Right
   - Left
   - Forward
   - Backward
7. Loss of balance when walking. If you also veer or feel pulled to one side
   or other indication the direction: To the left To the right
8. My dizziness is constant.
10. My dizziness comes on suddenly.
11. I have no dizziness or imbalance between episodes.
12. I can tell when an episode is about to start by:
   How: __________________________________________
13. Date of my first dizzy spell: ___________________________
14. Date of my most recent episode: _________________________
15. On average, how often does you dizziness happen: _____________

**Exacerbating and Remitting Factors:**

16. Turning my head left/right makes dizziness start or worsen.
17. Lying down or sitting up brings on my dizziness.
Yes  No  18. Standing up brings on my dizziness.

Yes  No  19. Walking in the dark is especially difficult

Yes  No  20. There is a relationship between my dizziness and tension, stress or anxiety in my life. Explain:

_____________________________________________________________

Yes  No  21. Does anything make your dizziness better? What:_____________________

Associated Symptoms

Yes  No  22. Nausea or vomiting?

Yes  No  23. Sweating?

Yes  No  24. Deafness or difficulty hearing?
   Ear:  Left     Right

Yes  No  25. Noises in ear (buzzing, ringing, roaring)
   Ear:  Left     Right

Yes  No  26. Change in the noise in ear when dizzy?

Yes  No  27. Fullness or pain in ears?
   Ear:  Left     Right

Yes  No  28. Drainage from ears?
   Ear:  Left     Right

Yes  No  29. Headache or pressure in head with dizziness?
   During      After
   Where?_____________________________

Migraine Headaches? If yes how often?________________________

Yes  No  30. Double vision, blurred vision, blindness?

Yes  No  31. Weakness or clumsiness in arms/legs?

Yes  No  32. Difficulty with speech or swallowing?

Yes  No  33. Neck or back pain?

Yes  No  34. Depression or anxiety?

Predisposing Factors:

Yes  No  35. Head Injury concussion, skull fracture, knocked unconscious?
Yes  No  36. Whiplash or neck pain?

Yes  No  37. Eye disorder or eye surgery?
Yes  No  38. Ear infections or other ear disease?

Yes  No  39. Did you begin taking prescription or nonprescription medication regularly before your dizziness started? If so what? ______________________________

Yes  No  40. Drink Alcohol: per day:_______________

years:_____________________

Patient:____________________________________________________Date:________________________________________