## The Dizziness Handicap Inventory ( DHI )

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| P1. Does looking up increase your problem? | o Yes<br>o Sometimes<br>o No |
| E2. Because of your problem, do you feel frustrated? | o Yes<br>o Sometimes<br>o No |
| F3. Because of your problem, do you restrict your travel for business or recreation? | o Yes<br>o Sometimes<br>o No |
| P4. Does walking down the aisle of a supermarket increase your problems? | o Yes<br>o Sometimes<br>o No |
| F5. Because of your problem, do you have difficulty getting into or out of bed? | o Yes<br>o Sometimes<br>o No |
| 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? | o Yes<br>o Sometimes<br>o No |
| F7. Because of your problem, do you have difficulty reading? | o Yes<br>o Sometimes<br>o No |
| P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems? | o Yes<br>o Sometimes<br>o No |
| E9. Because of your problem, are you afraid to leave your home without having someone accompany you? | o Yes<br>o Sometimes<br>o No |
| E10. Because of your problem have you been embarrassed in front of others? | o Yes<br>o Sometimes<br>o No |
| P11. Do quick movements of your head increase your problem? | o Yes<br>o Sometimes<br>o No |
| F12. Because of your problem, do you avoid heights? | o Yes<br>o Sometimes<br>o No |
| P13. Does turning over in bed increase your problem? | o Yes<br>o Sometimes<br>o No |
| F14. Because of your problem, is it difficult for you to do strenuous homework or yard work? | o Yes<br>o Sometimes<br>o No |
| E15. Because of your problem, are you afraid people may think you are intoxicated? | o Yes<br>o Sometimes<br>o No |
| F16. Because of your problem, is it difficult for you to go for a walk by yourself? | o Yes<br>o Sometimes<br>o No |
| P17. Does walking down a sidewalk increase your problem? | o Yes<br>o Sometimes<br>o No |
| E18.Because of your problem, is it difficult for you to concentrate | o Yes<br>o Sometimes<br>o No |
| F19. Because of your problem, is it difficult for you to walk around your house in the dark? | o Yes<br>o Sometimes<br>o No |

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| E20. Because of your problem, are you afraid to stay home alone? | o Yes<br>o Sometimes<br>o No |
| E21. Because of your problem, do you feel handicapped? | o Yes<br>o Sometimes<br>o No |
| E22. Has the problem placed stress on your relationships with members of your family or friends? | o Yes<br>o Sometimes<br>o No |
| E23. Because of your problem, are you depressed? | o Yes<br>o Sometimes<br>o No |
| F24. Does your problem interfere with your job or household responsibilities? | o Yes<br>o Sometimes<br>o No |
| P25. Does bending over increase your problem? | o Yes<br>o Sometimes<br>o No |


Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990;116: 424-427

## 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:
No=0 Sometimes=2 Yes=4

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)

**Vestibular Questionnaire**: Patient: _____Date:_____

**Characterize your dizziness**:

Yes No 1. Light-headedness, faintness, giddiness.

Yes No 2. Unsteadiness, imbalance

Yes No 3. Objects are spinning around you and you are still.

Yes No 4. You are spinning around and objects around you are still.

Yes No 5. You blackout or lose consciousness

Yes No 6. Tendency to fall. Please circle the direction (s)
Right Left Forward Backward

Yes No 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

Yes No 8. My dizziness is constant.

Yes No 9. My dizziness comes in attacks/spells.

Yes No 10. My dizziness comes on suddenly.

Yes No 11. I have no dizziness or imbalance between episodes.

Yes No 12. I can tell when an episode is about to start by:

How:_____

Yes No 13. Date of my first dizzy spell: _____

Yes No 14. Date of my most recent episode: _____

Yes No 15. On average, how often does you dizziness happen: _____

Exacerbating and Remitting Factors:

Yes No 16. Turning my head left/right makes dizziness start or worsen.

Yes No 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:_____