Dr Peter Friedland
Adult & Paediatric Ear, Nose and Throat

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Dizziness Handicap Inventory

Name: ______________________________ Date: ______________

Reason for visit: ______________________________

The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness.
Please answer every question.

Describing your dizziness

	Question	Yes	Sometimes	No
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 business or recreation travel?	☐ 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 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 yardwork?	☐ 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 footpath 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 walk around 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 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

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