

DIZZINESS HANDICAP INVENTORY (DHI)

Initial Visit/Follow-Up/Discharge

PATIENT NAME: _____ DATE: _____

PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS.

- P1 Does looking up increase your problem? YES SOMETIMES NO
- E2 Because of your problem, do you feel frustrated? YES SOMETIMES NO
- F3 Because of your problem, do you restrict your travel for business or recreation? YES SOMETIMES NO
- P4 Does walking down the aisle of a supermarket increase your problem? YES SOMETIMES NO
- F5 Because of your problem, do you have difficulty getting into or out of bed? YES SOMETIMES 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? YES SOMETIMES NO
- F7 Because of your problem, do you have difficulty reading? YES SOMETIMES NO
- P8 Does performing more ambitious activities, such as sports, dancing or household chores (sweeping or putting dishes away), increase your problems? YES SOMETIMES NO
- E9 Because of your problem, are you afraid to leave your home without having someone accompany you? YES SOMETIMES NO
- E10 Because of your problem, have you been embarrassed in front of others? YES SOMETIMES NO
- P11 Do quick movements of your head increase your problem? YES SOMETIMES NO
- F12 Because of your problem, do you avoid heights? YES SOMETIMES NO
- P13 Does turning over in bed increase your problem? YES SOMETIMES NO
- F14 Because of your problem, is it difficult for you to do strenuous housework or yard work? YES SOMETIMES NO
- E15 Because of your problem, are you afraid people may think you are intoxicated? YES SOMETIMES NO
- F16 Because of your problem, is it difficult for you to go for a walk by yourself? YES SOMETIMES NO
- P17 Does walking down a sidewalk increase your problem? YES SOMETIMES NO
- E18 Because of your problem, is it difficult for you to concentrate? YES SOMETIMES NO
- F19 Because of your problem, is it difficult for you to walk around your house in the dark? YES SOMETIMES NO
- E20 Because of your problem, are you afraid to stay home alone? YES SOMETIMES NO
- E21 Because of your problem, do you feel handicapped? YES SOMETIMES NO
- E22 Has the problem placed stress on your relationships with family members or friends? YES SOMETIMES NO
- E23 Because of your problem, are you depressed? YES SOMETIMES NO
- F24 Does your problem interfere with your job or household responsibilities? YES SOMETIMES NO
- P25 Does bending over increase your problem? YES SOMETIMES NO

Used with permission from GP Jacobson. Jacobson GP, Newman CW:
The Development of the Dizziness Handicap Inventory.
Arch Otolaryngol. Head Neck Surg 1990;116: 424-427

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

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Score P: _____ E: _____ F: _____

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