HONORHEALTH®

Dizziness Inventory

Name:_____ Date:_____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please only circle one answer for each question and answer all questions.

P 1. Does looking up increase your problem?	Yes	Sometimes	No
E 2. Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F 3. Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P 4. Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
F 5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F 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
F 7. Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
E 9. Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
E 10. Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
P 11. Do quick movements of your head increase your problem?	Yes	Sometimes	No
F 12. Because of your problem, do you avoid heights?	Yes	Sometimes	No
P 13. Does turning over in bed increase your problem?	Yes	Sometimes	No
F 14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E 15. Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
F 16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P 17. Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E 18. Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F 19. Because of your problem, is it difficult for you to go for a walk around your house in the dark?	Yes	Sometimes	No
E 20. Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E 21. Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E 22. Has your problem placed stress on your relationship with members of your family or friends?	Yes	Sometimes	No
E 23. Because of your problem, are you depressed?	Yes	Sometimes	No
F 24. Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
P 25. Does bending over increase your problem?	Yes	Sometimes	No