

DIZZINESS HANDICAP INVENTORY

Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please indicate answer by checking off "yes", "no" or "sometimes" for each question. Answer each question as it pertains to your dizziness or unsteadiness problem only.

	YES	NO	SOMETIMES
1. Does looking up increase your problem?	_____	_____	_____1
2. Because of your problem, do you feel frustrated?	_____	_____	_____2
3. Because of your problem, do you restrict your travel for business or recreation?	_____	_____	_____3
4. Does walking down the aisle of a supermarket increase your problem?	_____	_____	_____4
5. Because of your problem, do you have difficulty getting into or out of bed?	_____	_____	_____5
6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?	_____	_____	_____6
7. Because of your problem, do you have difficulty reading?	_____	_____	_____7
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	_____	_____	_____8
9. Because of your problem, are you afraid to leave your home without someone accompanying you?	_____	_____	_____9
10. Because of your problem, have you been embarrassed in front of others?	_____	_____	_____10
11. Do quick movements of your head increase your problem?	_____	_____	_____11
12. Because of your problem, do you avoid heights?	_____	_____	_____12
13. Does turning over in bed increase your problem?	_____	_____	_____13
14. Because of your problem is it difficult for you to do strenuous housework or yard work?	_____	_____	_____14
15. Because of your problem, are you afraid people might think you are intoxicated?	_____	_____	_____15
16. Because of your problem, is it difficult for you to go for a walk by yourself?	_____	_____	_____16
17. Does walking down a sidewalk increase your problem?	_____	_____	_____17
18. Because of your problem, is it difficult for you to concentrate?	_____	_____	_____18
19. Because of your problem, is it difficult for you to walk around your house in the dark?	_____	_____	_____19
20. Because of your problem, are you afraid to stay home alone?	_____	_____	_____20
21. Because of your problem, do you feel handicapped?	_____	_____	_____21
22. Has your problem placed stress on your relationships with members of your family or friends?	_____	_____	_____22
23. Because of your problem, are you depressed?	_____	_____	_____23
24. Does your problem interfere with your job or household responsibilities?	_____	_____	_____24
25. Does bending over increase your problem?	_____	_____	_____25
Thank you. Please bring this to your appointment.			_____/100

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PATIENT IDENTIFICATION



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THIS FORM IS A MEDICAL RECORD