

Patient Name

DOB:

MR #

**UW Health**  
**(University of Wisconsin Hospitals and Clinics Authority)**  
**DIZZINESS HANDICAP INVENTORY (DHI)**

**Answer each question as it pertains to your dizziness problem only.**

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

**Total:** \_\_\_\_\_