Kos/Danchak
AUDIOLOGY & HEARING AIDS

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

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

For Office Use Only

Score P: ________ E: ________ F: ________

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