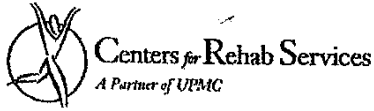


Name   
 DOB   
 Date

### Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please answer "Yes", "No" or "Sometimes" to each question. Answer each question as it pertains to your dizziness problem only.

|                                                                                                                                                                     | YES                      | SOMETIMES                | NO                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Does looking up increase your problem?                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Because of your problem, do you feel frustrated?                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Because of your problem, do you restrict your travel for business or recreation?                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does walking down the aisle of a supermarket increase your problem?                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Because of your problem, do you have difficulty getting out of bed?                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Because of your problem, do you have difficulty reading?                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does performing more ambitious activities like sports, dancing, household chores, such as sweeping or putting dishes away, increase your problem?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Because of your problem, are you afraid to leave your home without having someone to accompany you?                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Because of your problem, have you been embarrassed in front of others?                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do quick movements of your head increase your problems?                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Because of your problem, do you avoid heights?                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



Name

DOB

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### Dizziness Handicap Inventory (DHI)

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please answer "Yes", "No" or "Sometimes" to each question. Answer each question as it pertains to your dizziness problem only.

|                                                                                                 | YES                      | SOMETIMES                | NO                       |
|-------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 13. Does turning over in bed increase your problem?                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Because of your problem, is it difficult for you to do strenuous housework or yard work?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Because of your problem, are you afraid people may think that you are intoxicated?          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Because of your problem, is it difficult for you to walk by yourself?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does walking down a sidewalk increase your problem?                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Because of your problem, is it difficult for you to concentrate?                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Because of your problem, is it difficult for you to walk around your house in the dark?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Because of your problem, are you afraid to stay at home alone?                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Because of your problem, do you feel handicapped?                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has your problem placed stress on your relationship with members of your family or friends? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Because of your problem, are you depressed?                                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Does your problem interfere with your job or house responsibilities?                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does bending over increase your problem?                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |