Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "always", or "no" or "sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	Always	Sometimes	No
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or pleasure?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
F8	Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?	☐	☐	☐
E10	Because of your problem, have you been embarrassed in front of others?	☐	☐	☐
P11	Do quick movements of your head increase your problem?	☐	☐	☐
F12	Because of your problem, do you avoid heights?	☐	☐	☐
P13	Does turning over in bed increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think that you are intoxicated?	☐	☐	☐
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17	Does walking down a sidewalk increase your problem?	☐	☐	☐
E18	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
E20	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has your problem placed stress on your relationship with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

Scoring for Dizziness Handicap Inventory

Eval	Total Functional	Total Emotional	Total Physical	TOTAL SCORE
Reassess #1				
Reassess #2				
Reassess #3				
Reassess #4				

Always = 4

Sometimes = 2

No = 0

P = physical
E = emotional
F = functional
Subscales

Notes:

1. Subjective measure of the patient's perception of handicap due to the dizziness
2. Top score is 100 (maximum perceived disability)
3. Bottom score is 0 (no perceived disability)
4. The following 5 items can be useful in predicting BPPV
   - Does looking up increase your problem?
   - Because of your problem, do you have difficulty getting into or out of bed?
   - Do quick movements of your head increase your problem?
   - Does bending over increase your problem?
5. Can use subscale scores to track change as well

Patient History (initial Eval)

Date:

Patient Name:_____ **Age:**_____ **Occupation:**_____
Referring Physician: _____

Systems Review
Other current medical issues:

Joint pain? **Y/ N** Neck pain? **Y/ N** Back pain? **Y/ N** Ability to lay supine for positioning maneuvers if needed? **Y/ N**

PMH: Heart conditions, High Blood Pressure, Hypotension, DM, High Cholesterol HA's or migranes
Hx of infection, Recent antibiotic use, Osteoporosis, CA, Falls, Head trauma MS,
CVA: any residual effects?

Red Flags:

- Have you currently been experiencing unexplained abnormal fatigue, SOB, slurred speech, difficulty swallowing
- blurred vision, double vision numbness tingling, poor coordination, unexplained weight loss/gain,
- unexplained weakness/ loss of strength in arms/legs bowel or bladder difficulty,
  passed out recently or lost consciousness?

Hearing Loss? Y/ N **Side?** Right/ None / Left ~ *(labrynthitis, Menieres, Vestibular schwanomma, SCD)*
Tinnitus: Right / Left
Has the loss been **gradual** or **sudden**?
Hearing test (Audiogram) done recently ? Y/ N

Medical Tests: **MRI** **CT scan** **Smoke?** Y/ N **Drink** Y/ N

History of current issue:
Date of Onset: What were you doing when it came on?

Vertigo (spinning) **Imbalanced** (unsteadiness) **Faint** (light head/pass out)

Spontaneous (nothing you think you can do to trigger it) or is it brought on by **positional Changes** or **non-specific head movement**?

Worse with? Laying down in bed, Sitting up in bed, Rolling over in bed R / L Looking side to side?
Standing up quickly, Bending forward, Pitching head back, *BPPV*

How long did your initial episode last?:

sec	**min**	**hours**	**day(s)**	**weeks**
BPPV (canal)	BPPV (cupulo)	Meniere's	Neuritis	CNS
SCD	TIA		Labyrinthitis	Psychiatric
			Vestibular ischemia	

Are there any other symptoms that come along with the dizziness?

Nausea	Vomiting	Loss of Balance	Oscillopsia	Headache	Diplopia
Visual loss	Dysarthria	Sensory disturbances	Limb incoordination	Falls	Hiccups

What relieves your symptoms?

Does sneezing, coughing, holding your breath or specific sounds exacerbate your dizziness? *Superior Canal Dehisence*
Associated sensitivity to lights, sounds or odors with your dizziness? Hormonally triggered? Headaches? *Migraine related dizziness*

Is your dizziness recurrent?

How often does an episode recur? Duration of recurrences?

Improving / Worse / Same? Prior treatment?