

# Vestibular - Dizziness Handicap Index

REDCap ID \_\_\_\_\_

Visit Date: \_\_\_\_\_

Visit Type:  Initial visit  Medial visit  
 Final visit

Diagnostic Complexity  BPPV  
 Unilateral Vestibular  
 Bilateral Vestibular  
 Other

Define Diagnostic Complexity \_\_\_\_\_

Patient has had surgery for the current condition?  Yes  No

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 clicking "yes or "no" or "sometimes" for each question.

I have dizziness / unsteadiness:  Once per month  
 More than once but less than 4 times per month  
 More than once per week  
 Never

My dizziness / unsteadiness is:  Mild  
 Moderate  
 Severe  
 Never

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## Answer each question as it pertains to your dizziness or unsteadiness problem only.

	Yes	No	Sometimes
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 into or 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 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 away dishes increase your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Sometimes
9. Because of your problem, are you afraid to leave your home without having someone 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 problem?	<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"/>
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 might think you are intoxicated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Sometimes
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 walk around the house in the dark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Because of your problem, are you afraid to stay 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 relationships with members of your family or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 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?

Please indicate which best describes you.

- Negligible symptoms
- Bothersome symptoms
- Performs usual work duties but symptoms interfere with outside activities
- Symptoms disrupt performance of both usual work duties and outside activities
- Currently on medical leave or had to change jobs because of symptoms
- Unable to work for over one year or established permanent disability with compensation payments

Please stop here and return the tablet or form to staff member.

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**For staff use**

Physical Items (28) \_\_\_\_\_

Emotional Items (36) \_\_\_\_\_

Functional Items (36) \_\_\_\_\_

Total (100) \_\_\_\_\_

G Code:  
\_CH\_

G Code:  
\_CI\_

G Code:  
\_CJ\_

G Code:  
\_CK\_

G Code:  
\_CL\_

G Code:  
\_CM\_

G Code:  
\_CN\_