DIZZY FEELINGS

NAME: ______________________________________ DATE: ________________

DOB: ____

Please circle the feelings you are calling DIZZINESS:

reeling	drunk	blurry vision
giddy	whirling	faint
warm	undulating	lightheaded
not able to concentrate	anxious	pain
off balance	floating	drifting
clumsy	dazed	falling
swimmy-headed	fluttering	sick
disoriented	confused	swaying
weak	heavy-headed	headache
leaning	spinning	listing
fuzzy-headed	lack of memory	a rush
focus problems	shaky	nauseated
spacey	being pulled	staggering
	vertigo	fatigued

other: ____

____

What symptoms do you have other than dizziness?

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NAME: ______________________________________ DATE: ________________

DOB: ____

DIZZINESS QUESTIONNAIRE

	YES	NO	SOMETIMES
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 recreation?			
P4. Does walking down the aisle of a supermarket increase your problem?			
F5. Because of your problem, do you have difficulty getting out of bed?			
F6. Does your problem significantly restrict your participation in social activities such as going to the movies, dinner, dancing, and parties?			
F7. Because of your problem, do you have difficulty reading?			
P8. Does doing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?			
E9. Because of your problem, have you been afraid to leave your home without having someone accompanying 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 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 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 relationships 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?			
Totals			
TOTAL SCORE			

“Dizziness Handicapped Index” Jacobson, Newman: Arch Otolaryngol Head Neck Surg 116:424, 1990

100-70=severe perception of having a handicap; 69-40=moderate perception of handicap;

39-0=low perception of handicap

F indicated Functional subscale; E, Emotional subscale; P, Physical subscale

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