

Patient Label

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing **because of your dizziness or unsteadiness**. Please answer “yes”, “no”, or “sometimes” to each question.

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|---|-----|----|-----------|-----|
| 1. Does looking up increase your problem? | Yes | No | Sometimes | (P) |
| 2. Because of your problem, do you feel frustrated? | Yes | No | Sometimes | (E) |
| 3. Because of your problem, do you restrict your travel for business or recreation? | Yes | No | Sometimes | (F) |
| 4. Does walking down the aisle of a supermarket increase your problem? | Yes | No | Sometimes | (P) |
| 5. Because of your problem, do you have difficulty getting into or out of bed? | Yes | No | Sometimes | (F) |
| 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? | Yes | No | Sometimes | (F) |
| 7. Because of your problem, do you have difficulty reading? | Yes | No | Sometimes | (F) |
| 8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem? | Yes | No | Sometimes | (P) |
| 9. Because of your problem, are you afraid to leave your home without having someone accompany you? | Yes | No | Sometimes | (E) |
| 10. Because of your problem, have you been embarrassed in front of others? | Yes | No | Sometimes | (E) |
| 11. Do quick movements of your head increase your problem? | Yes | No | Sometimes | (P) |
| 12. Because of your problem, do you avoid heights? | Yes | No | Sometimes | (F) |
| 13. Does turning over in bed increase your problem? | Yes | No | Sometimes | (P) |
| 14. Because of your problem, is it difficult for you to do strenuous housework or yard work? | Yes | No | Sometimes | (F) |
| 15. Because of your problem, are you afraid people might think you are intoxicated? | Yes | No | Sometimes | (E) |
| 16. Because of your problem, is it difficult for you to go for a walk by yourself? | Yes | No | Sometimes | (F) |
| 17. Does walking down a sidewalk increase your problem? | Yes | No | Sometimes | (P) |
| 18. Because of your problem, is it difficult for you to concentrate? | Yes | No | Sometimes | (E) |
| 19. Because of your problem, is it difficult for you to walk around the house in the dark? | Yes | No | Sometimes | (F) |
| 20. Because of your problem, are you afraid to stay home alone? | Yes | No | Sometimes | (E) |
| 21. Because of your problem, do you feel handicapped? | Yes | No | Sometimes | (E) |
| 22. Has your problem placed stress on your relationships with family or friends? | Yes | No | Sometimes | (E) |
| 23. Because of your problem, are you depressed? | Yes | No | Sometimes | (E) |
| 24. Does your problem interfere with your job or household responsibilities? | Yes | No | Sometimes | (F) |
| 25. Does bending over increase your problem? | Yes | No | Sometimes | (P) |

T= /100 P= /28 E= /36 F= /36 Date —