

## **DIZZINESS PATIENT-ORIENTED SEVERITY INDEX COPYRIGHT NOTICE**

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NAME \_\_\_\_\_ DATE \_\_\_\_\_

## VESTIBULAR AND OCULOMOTOR LABORATORY

### DIZZINESS PATIENT-ORIENTED SEVERITY INDEX

To let us know more about your health, please answer the following questions about the physical problems, activity limitations, and emotional consequences of your dizziness. There are no "right" or "wrong" answers, and only YOU can provide this information. Because we want to know how you feel about your problems, whenever a statement represents an area or activity of your life where you have a problem, please indicate HOW MUCH OF A PROBLEM it is to you. If a statement is not appropriate to your situation or if you are not having a problem in this area, circle the "0" and go on to the next statement.

	No Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	5 Most Important Items
<p>1. Considering how severe the dizziness is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →</p>					
<b>A. PHYSICAL PROBLEMS</b>					
1. Quickly move your head	0	1	2	3	○
2. Turn over in bed	0	1	2	3	○
3. Get into or out of bed	0	1	2	3	○
4. Bend over	0	1	2	3	○
5. Look up	0	1	2	3	○
6. Read	0	1	2	3	○
7. Need to concentrate for long periods	0	1	2	3	○
8. Are at high heights	0	1	2	3	○
9. See motion of objects around you (ie, sitting in a moving train)	0	1	2	3	○
<b>B. ACTIVITY PROBLEMS</b>					
10. Difficult for you to stay home alone	0	1	2	3	○
11. Difficult for you to walk around the house in the dark	0	1	2	3	○
12. Difficult to walk down the aisle of a supermarket	0	1	2	3	○
13. Difficult to walk down a sidewalk	0	1	2	3	○
14. Difficult for you to go for a walk by yourself	0	1	2	3	○

2. Please mark the most important items affecting your health \_\_\_\_\_  
(maximum of 5 items from total list of 30)



1. Considering how severe the dizziness is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →

	No Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	5 Most Important Items
<b>B. ACTIVITY PROBLEMS (cont.)</b>					
15. Difficult to leave home without having someone accompany you	0	1	2	3	<input type="radio"/>
16. Difficult to go out to dinner, movies, dancing, or to parties	0	1	2	3	<input type="radio"/>
17. Difficult to perform sexual activities	0	1	2	3	<input type="radio"/>
<b>TO WHAT EXTENT DOES YOUR DIZZINESS MAKE IT --</b>					
18. Difficult to participate in community or volunteer activities	0	1	2	3	<input type="radio"/>
19. Difficult to perform more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes	0	1	2	3	<input type="radio"/>
20. Difficult to participate in religious or spiritual activities	0	1	2	3	<input type="radio"/>
21. Difficult to drive a car	0	1	2	3	<input type="radio"/>
22. Difficult for you to travel for business or recreation	0	1	2	3	<input type="radio"/>
23. Difficult for you to do strenuous housework or yardwork	0	1	2	3	<input type="radio"/>
24. Feel frustrated	0	1	2	3	<input type="radio"/>
25. Embarrassed in front of others	0	1	2	3	<input type="radio"/>
26. Feel depressed or sad	0	1	2	3	<input type="radio"/>
27. Experience marital stress or tension	0	1	2	3	<input type="radio"/>
28. Feel that you are a burden to others	0	1	2	3	<input type="radio"/>
29. Unable to relax; always anxious	0	1	2	3	<input type="radio"/>
30. Afraid people may think you are intoxicated	0	1	2	3	<input type="radio"/>

2. Please mark the most important items affecting your health \_\_\_\_\_  
 (maximum of 5 items from total list of 30)

