Vestibular Patient Inventory Patient Name:_____Date:_____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness, unsteadiness or falling. Please answer every question. Please do not skip any questions. Please follow the key below with all of your answers.

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
4 = I frequently have symptoms (75% of the time)
5 = I always have symptoms (100% of the time)

1. Does looking up increase your problem? (0 1 2 3 4 5)

2. Because of your problem, do you feel frustrated? (0 1 2 3 4 5)

3. Because of your problem, do you restrict your travel for business or recreation? (0 1 2 3 4 5)

4. Does walking down the aisle of a supermarket increase your problem? (0 1 2 3 4 5)

5. Because of your problem, do you have difficulty getting into or out of bed? (0 1 2 3 4 5)

6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? (0 1 2 3 4 5)

7. Because of your problem, do you have difficulty reading? (0 1 2 3 4 5)

8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? (0 1 2 3 4 5)

9. Because of your problem, are you afraid to leave home without having someone with you? (0 1 2 3 4 5)

10. Because of your problem, have you been embarrassed in front of others? (0 1 2 3 4 5)

11. Do quick movements of your head increase your problem? (0 1 2 3 4 5)

12. Because of your problem, do you avoid heights? (0 1 2 3 4 5)

13. Does turning over in bed increase your problem? (0 1 2 3 4 5)

14. Because of your problem, is it difficult for you to do strenuous housework or yard work? (0 1 2 3 4 5)

15. Because of your problem, are you afraid people may think you are intoxicated? (0 1 2 3 4 5)

16. Because of your problem, is it difficult for you to go for a walk by yourself? (0 1 2 3 4 5)

17. Does walking down a sidewalk increase your problem? (0 1 2 3 4 5)

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18. Because of your problem, is it difficult for you to concentrate? (0 1 2 3 4 5)

19. Because of your problem, is it difficult for you to go for a walk around your house in the dark? (0 1 2 3 4 5)

20. Because of your problem, are you afraid to stay home alone? (0 1 2 3 4 5)

21. Because of your problem, do you feel handicapped? (0 1 2 3 4 5)

22. Has your problem placed stress on your relationship with members of your family or friends? (0 1 2 3 4 5)

23. Because of your problem, are you depressed? (0 1 2 3 4 5)

24. Does your problem interfere with your job or household responsibilities? (0 1 2 3 4 5)

25. Does bending over increase your problem? (0 1 2 3 4 5)

26. Do you feel that your body is spinning to the right? (0 1 2 3 4 5)

27. Do you feel that your body is spinning to the left? (0 1 2 3 4 5)

28. Do you fee that the room is spinning to the right? (0 1 2 3 4 5)

29. Do you feel that the room is spinning to the left? (0 1 2 3 4 5)

30. Do you feel that you are falling forwards or backwards? (0 1 2 3 4 5)

31. Do you have illusions of unusual room movement? (0 1 2 3 4 5)

32. Does straining make your problems worse? (0 1 2 3 4 5)

33. Do you get your problems after eating? (0 1 2 3 4 5)

34. Do you ever fall? (0 1 2 3 4 5)

35. Do you have ringing in your ears? (0 1 2 3 4 5)

36. Do you have double vision? (0 1 2 3 4 5)

37. Do you have perceived hearing loss? (0 1 2 3 4 5)

38. Do you have any numbness or sensory changes in your legs or arms? (0 1 2 3 4 5)

39. Do you have any weakness in your arms, legs or face? (0 1 2 3 4 5)

40. Have you had any loss in smell? (0 1 2 3 4 5)

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41. Have you had any loss in vision? (0 1 2 3 4 5)

42. Do you have any tremors or abnormal movement? (0 1 2 3 4 5)

43. Do you have headaches? (0 1 2 3 4 5)

44. Do you have seizures? (0 1 2 3 4 5)

45. Do you get recurrent viral or bacterial infections (0 1 2 3 4 5)

46. Do you have problems talking? (0 1 2 3 4 5)

47. Do you have problems swallowing? (0 1 2 3 4 5)

48. Does anyone else in your immediate family have similar symptoms? (Yes / No)

49. Please circle any of the following that you have had in your lifetime:

* Head trauma * Exposure to loud noises * Diabetes * Cancer
* Ear Infections * Exposure to toxic substances * Thyroid disease
* Herpes infections * Taking ototoxic medication * Autoimmune disease
* Head or neck surgery * Eye surgery * TMJ Surgery * Blood disorder
* Problems after scuba diving * Cardiovascular disease * Trauma to the ear

Patient Signature:_____Date:_____

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