Patient History: Voice

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Name_____ Age____ Sex_____ Date_____
Height_____ Weight_____

Describe your voice problem:

_____

_____

Do you have any of the following symptoms?
___Hoarseness (coarse or scratchy sound)
___Fatigue (voice tires or changes quality after short period of use)
___Problems singing/speaking loudly
___Problems singing softly
___Loss of range (describe_____)
___Prolonged warm-up time
___Breathiness
___Tickling or choking sensation while speaking/singing
___Pain in throat
___Other_____

How long have you had your present voice problem?_____
Do you know what caused it?_____
Did it come on___slowly or ____quickly?
Is it getting___Better__Worse___Same?

Have you ever had a voice problem before? ___Yes ___No
What was the problem?_____
How was it treated?_____

Do you smoke?___ Yes___ No How much per day?_____ How long?_____
Do you drink alcohol? ___Yes ___No How much?_____
Do you drink caffeinated beverages? ___Yes ___No How much per day?_____

Have you ever had training for your speaking voice? ____Yes ____No
Current teacher's name_____
Address _____
Telephone_____

What is your occupation? _____
How much are you speaking at present (hours per day)
Work_____ Rehearsals ____ Performances ____ Other____

Please check any of the following that apply to you.

___Voice worse in the morning
___Frequent heartburn
___Frequent throat clearing
___Frequent sore throat
___Bitter or acid taste in the morning
___Bad breath in the morning
___Eat late at night
___Voice worse after use
___Frequent yelling or loud talking
___Frequent whispering
___Often thirsty or dehydrated
___Live or work around smoke or fumes
___Frequent coughing
___Speak extensively

Family Doctor:
Name:_____
Address:_____
Telephone:_____
Would you like me to keep this person informed about your treatment? ___Yes ___ No

Prior Laryngologist:
Name_____
Address_____
Telephone_____
Would you like me to keep this person informed about your treatment? ___Yes ___ No

Medical History

What medications are you currently taking?_____
_____

Do you have any drug allergies? _____
_____

Have you had any of the following illnesses:

___heart murmur
___heart attack
___high blood pressure
___other heart disease
___emphysema/asthma
___allergies
___anemia
___bleeding disorder
___jaundice/hepatitis
___ulcer
___arthritis
___thyroid trouble
___tumor
___phlebitis
___tuberculosis
___epilepsy
___kidney/bladder trouble
___glaucoma/cataracts
___nervous disorder
___cancer

Other:_____

What medical problems run in your family?

Father_____

Mother_____

Brothers/sisters_____

Children_____

Place an (x) alongside each of the symptoms you are concerned about:

__poor appetite
__weight gain
__weight loss
__fever, chills
__excess sweating
__fatigue

__trouble with vision
__eye pain or redness
__hearing trouble
__ear pain or discharge
__ringing of ears
__nose bleeds
__nasal discomfort
__throat discomfort
__voice change
__dental or gum symptoms

__cough
__sputum
__bloody sputum
__wheezing
__chest pains
__heart “skipping” palpitations)
__shortness of breath

__swollen feet or ankles
__leg pains
__leg ulcers
__varicose veins

__jaundice
__heartburn
__difficulty swallowing
__special food intolerance
__abdominal pain
__nausea
__vomiting
__vomiting blood
__belching or flatulence
__black stools, rectal bleeding
__rectal discomfort
__diarrhea

__backache
__arthritis or joint pain
__”bursitis”
__muscular aches

__burning on urination
__frequency of urination

__nighttime urination
__urgency of urination
__difficulty starting urination
__loss of control of urine
__pus in urine
__blood in urine
__bruise or bleed easily

__swollen glands
__hot weather intolerance
__cold weather intolerance
__increased thirst
__increased urine volume

__skin problems
__hair or nail problems
__itching

__headaches
__dizziness
__fainting
__numbness, pins and needles
__tremor
__muscle weakness or paralysis
__seizures, convulsions
__faulty memory

__nervousness
__depression
__trouble sleeping
__work or family problems
__sexual problems
__unusual fears

MEN:
__weak urine stream
__prostate trouble
__discharge from penis
__painful or swollen testes

WOMEN:
__trouble with menstruation
__vaginal discharges
__hot flashes
__breast lump or discharge

Name_____ Date_____

Within the last MONTH, how did the following problems affect you: (0= No problem, 5=severe problem)

Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excessive throat mucous or postnasal drip	0	1	2	3	4	5
Difficulty swallowing	0	1	2	3	4	5
Coughing after you finish eating/drinking or after lying down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion or stomach acid coming up	0	1	2	3	4	5

These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

	never	almost never	sometimes	almost always	always	
My voice makes it difficult for people to hear me.	0	1	2	3	4	
People have difficulty hearing me when I call them throughout the house.	0	1	2	3	4	
I use the phone less often that I would like	0	1	2	3	4	
I tend to avoid groups of people because of my voice.	0	1	2	3	4	
I speak with friends, neighbors or relatives less often because of my voice.	0	1	2	3	4	
People ask me to repeat myself when speaking face-to-face.	0	1	2	3	4	
My voice difficulties restrict personal and social life.	0	1	2	3	4	
I feel left out of conversations because of my voice.	0	1	2	3	4	
My voice problem causes me to lose income.	0	1	2	3	4	
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I run out of air when I talk.	0	1	2	3	4	
The sound of my voice varies throughout the day.	0	1	2	3	4	
People ask, “What’s wrong with your voice?”	0	1	2	3	4	
My voice sounds creaky and dry.	0	1	2	3	4	
I feel as though I have to strain to produce voice.	0	1	2	3	4	
The clarity of my voice is unpredictable.	0	1	2	3	4	
I try to change my voice to sound different.	0	1	2	3	4	
I use a great deal of effort to speak.	0	1	2	3	4	
My voice is worse in the evening.	0	1	2	3	4	
My voice “gives out” on me in the middle of speaking.	0	1	2	3	4	
						P =
I am tense when talking to others because of my voice.	0	1	2	3	4	
People seem irritated with my voice.	0	1	2	3	4	
My voice problem upsets me.	0	1	2	3	4	
I am less outgoing because of my voice problem.	0	1	2	3	4	
My voice makes me feel handicapped.	0	1	2	3	4	
I feel annoyed when people ask me to repeat.	0	1	2	3	4	
I feel embarrassed when people ask me to repeat.	0	1	2	3	4	
My voice makes me feel incompetent.	0	1	2	3	4	
I am ashamed of my voice problem.	0	1	2	3	4	
						E=