PATIENT HISTORY: SINGERS

Name: _____ Age: ____ Sex: ___ Ethnic Background: _____

Height: _____ Weight: _____ Date: _____

Voice Category: ❑ Soprano ❑ Mezzo soprano ❑ Alto
❑ Tenor ❑ Baritone ❑ Bass
❑ Don't know

(If you are not currently having a voice problem, please skip to Question #3)
PLEASE CHECK OR CIRCLE CORRECT ANSWERS

1. How long have you had your present voice problem?
   Who noticed it?
   - ❑ Self
   - ❑ Voice teacher
   - ❑ Everyone
   - ❑ Family
   - ❑ critics
   - ❑ other_____

   Do you know what caused it? ☐ YES ☐ NO
   If yes, what? _____
   Did it come on slowly or suddenly? ☐slowly ☐suddenly
   Is it getting: ☐worse ☐better ☐same

2. Which symptoms do you have? **(Please check all that apply.)**
   - ❑ Hoarseness (coarse or scratchy sound)
   - ❑ Fatigue (voice tires or changes quality after singing for a short period of time)
   - ❑ Volume disturbances (trouble singing) softly_____ loudly_____
   - ❑ Loss of range (high_____ low_____)
   - ❑ Change in classification (example: voice lowered from soprano to mezzo)
   - ❑ Prolonged warm-up time (over ½ hrs. to warm up voice)
   - ❑ Breathiness
   - ❑ Voice just cuts out
   - ❑ Tickling or choking sensation while singing
   - ❑ Trouble with transition range
   - ❑ Pain in throat while singing
   - ❑ Other (please specify)_____
3. Do you have an important performance soon? ☐ Yes ☐ No
   Date(s):_____

4. What is the current status of your singing career? ☐ Professional ☐ Amateur

5. What are you long term goals in singing? ❑ Professional ❑ Amateur
   - ❑ Operatic career
   - ❑ Solo career
   - ❑ Career with a duo or group
   - ❑ Singing in group
   - ❑ Singing for own pleasure
   - ❑ Other_____

6. Have you had voice training? ☐ Yes ☐ No
   At what age did you begin?_____

7. Have there been periods of months or years without lessons in that time? ❑Yes ❑No

8. How long have you studied with your present teacher?_____
   Teacher's name:_____
   Teacher's address:_____
   Teacher's telephone number:_____

9. Please list past teacher(s) if there are any.

_____

_____

10. Have you ever had training for your speaking voice? ☐ Yes ☐ No

    Acting voice lessons? ☐ Yes ☐ No How long?_____

    Speech therapy? ☐ Yes ☐ No How long?_____

11. Employment
    - ❑ Actor
    - ❑ athletic instructor
    - ❑ clergy
    - ❑ physician
    - ❑ stock broker
    - ❑ telephone operator
    - ❑ server
    - ❑ singer
    - ❑ other_____
    - ❑ announcer(TV/radio/sports)
    - ❑ attorney
    - ❑ politician
    - ❑ sales person
    - ❑ educator
    - ❑ receptionist
    - ❑ administrative assistant

12. Which of these are present in your daily voice use?

	OFTEN	SOMETIMES	NEVER
Talking in a noisy environment	☐	☐	☐
Excessive speaking	☐	☐	☐
Shouting, screaming, yelling	☐	☐	☐
Coughing	☐	☐	☐
Throat-clearing	☐	☐	☐
Singing	☐	☐	☐

13. Any variation in your voice/throat problem during the day?
Best?_____ Worst? _____
Any variation with emotions?_____

14. How many years did you sing actively before beginning voice lessons initially?_____

15. What types of music do you sing? (Kindly check all that apply)

❑ Alternative ❑ Blues ❑ Gospel ❑ Jazz
❑ Opera ❑ Pop ❑ Rock ❑ Folk
❑ Rap ❑ Hip-Hop ❑ Classical ❑ Metal
❑ Country ❑ Adult contemporary ❑ Contemporary Christian
❑ Show/Broadway ❑ Urban Contemporary
❑ Other _____

16. Do you regularly sing in a sitting position (such as from behind a piano or drum set)?
☐ Yes ☐ No

17. Do you sing outdoors or in large halls, or with orchestras? (Please circle which one)
☐ Yes ☐ No

18. If you perform with electrical instruments or outdoors do you use monitor speakers?
☐ Yes ☐ No If yes, can you hear them? ☐ Yes ☐ No

19. Do you play a musical instrument(s)? ☐ Yes ☐ No
If yes, please check all that apply.
- ❑ Keyboard (Piano, Organ, Harpsichord, Other_____)
- ❑ Violin, Viola
- ❑ Cello
- ❑ Bass
- ❑ Plucked Strings (Guitar, Harp, Other_____)
- ❑ Brass ❑high (trumpet, French horn) ❑low (trombone, tuba)
- ❑ Wind with single reed ❑ double reed
- ❑ Flute, Piccolo
- ❑ Percussion
- ❑ Other (Please specify):_____

20. How often do you practice?

Scales : ☐ daily☐ few times weekly ❑once a week ❑rarely ❑never
If you practice scales, do you do them all at once or do you divide them up over the course of a day? ☐all at once ☐two or three sittings
On days when you do scales, how long do you practice them?
Minutes: ❑15 ❑30 ❑45 ❑60 ❑75 ❑105 ❑120 ❑ more than 120
Songs: ❑daily ❑few times weekly ❑ once a week ❑rarely ❑never
How many songs per day? ❑1/2 ❑1 ❑1 ½ ❑2 ❑2 ½ ❑3 ❑more than 3

Do you warm-up your voice before you sing? ☐ Yes ☐ No

Do you warm-down your voice when you are finished singing? ☐ Yes ☐ No

21. Please check all that apply to you:
- ❑ Cheerleader
- ❑ Speak extensively backstage or at post-performance parties
- ❑ Bitter or acid taste, or bad breath first thing in the morning
- ❑ Frequent "heartburn" or hiatal hernia
- ❑ Frequent yelling or loud talking
- ❑ Frequent whispering
- ❑ Chronic fatigue (insomnia)
- ❑ Work around extreme dryness
- ❑ Frequent exercise (weight lifting, aerobics, etc.)
- ❑ Frequently thirsty, dehydrated
- ❑ Eat late at night
- ❑ Ever used antacids
- ❑ Under particular stress at present (personal or professional)
- ❑ Frequent bad breath
- ❑ Live, work, or perform around smoke or fumes
- ❑ Traveled recently: When: _____ Where:_____

22. Do you often eat/drink/consume before singing? ❑ yes ❑ no
❑ Caffeine ❑ Chocolate ❑ Dairy products ❑ Spicy foods
❑ Alcohol ❑ Nuts ❑ Large portions ❑ Recreational drugs

23. Have you ever been evaluated by an allergist? ❑ yes ❑ no
If yes, please provide your allergists' contact information_____
_____
_____

If yes, what allergies do you have:

❑ none
❑ dust
❑ mold
❑ trees
❑ cats
❑ dogs
❑ foods
❑ other: _____

24. Smoking history: ☐ Never Quit. When:_____
☐Smoke(d) about ____ packs per day for _____ years

25. Do you work in a smoky environment: ❑Yes ❑No

26. How much alcohol do you drink?
☐ None ☐ Rarely ☐ A few times per week ☐ Daily

If daily, or a few times per week, on the average, how much do you consume?
❍1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10 ❍ more than 10 glasses,
Per ☐day ☐week of ☐beer ☐wine ☐liquor.

Did you used to drink more heavily? ❍ Yes ❍ No

27. Please list any recreational drugs you use:
❑ Amphetamines ❑ Cocaine ❑ Marijuana
❑ Heroin ❑ Ecstasy ❑ Other_____

28. How many cups of coffee, tea, cola or other caffeine-containing drinks do you drink per day? _____

29. How many glasses of water do you drink per day? _____

30. Have you noticed any of the following? (Check all that apply.)

- ❑ Hypersensitivity to heat or cold
- ❑ Excessive sweating
- ❑ Change in weight: gained/lost_____ lbs. in _____weeks/ _____months.
- ❑ Change in skin or hair
- ❑ Palpitation (fluttering) of the heart
- ❑ Emotional lability (swings of mood)
- ❑ Double vision
- ❑ Numbness of the face or extremities
- ❑ Tingling around the mouth or face
- ❑ Blurred vision or blindness
- ❑ Weakness or paralysis of the face
- ❑ Clumsiness in arms or legs
- ❑ Confusion or loss of consciousness
- ❑ Difficulty with speech
- ❑ Difficulty with swallowing
- ❑ Seizure (epileptic fit)
- ❑ Pain in the neck or shoulder
- ❑ Shaking or tremors
- ❑ Memory change
- ❑ Personality change

31. *Female Patients*:

Are you pregnant?	❍ Yes ❍ No
Are your menstrual periods regular?	❍ Yes ❍ No
Have you undergone a hysterectomy?	❍ Yes ❍ No
Were your ovaries removed?	❍ Yes ❍ No
At what age did you reach puberty? _____	
Have you gone through menopause?	❍ Yes ❍ No
If yes, when? _____	

32. Have you ever consulted a psychologist or psychiatrist? ❍ Yes ❍ No
    Are you currently under treatment? ❍ Yes ❍ No

33. Have you injured you head or neck (whiplash, etc.)? ❍ Yes ❍ No

34. Describe any serious accidents related to this visit. ❑ None

_____

35. Are you involved in legal action involving problems with your voice?
    ❑Yes ❑ No

36. Brief summary of ENT problems, some of which may not be related to your present complaint.
Please Check All That Apply

- ❑ Hearing loss
- ❑ Ear pain
- ❑ Ear noises
- ❑ Facial pain
- ❑ Dizziness
- ❑ Stiff neck
- ❑ Facial paralysis
- ❑ Lump in neck
- ❑ Nasal obstruction
- ❑ Nasal deformity
- ❑ Trouble swallowing
- ❑ Mouth sores
- ❑ Jaw joint problem
- ❑ Excess facial skin
- ❑ Eye problem
- ❑ Other: (please specify)_____

37. Do you have or have you ever had:

- ❑ Diabetes
- ❑ Seizures
- ❑ Hypoglycemia
- ❑ Psych. therapy
- ❑ Thyroid problems
- ❑ Frequent bad headaches
- ❑ Syphilis
- ❑ Kidney disease
- ❑ Cold sores (fever blisters)
- ❑ Arthritis or skeletal problems
- ❑ High blood pressure
- ❑ Cleft palate
- ❑ Asthma
- ❑ Lung or breathing problems
- ❑ Heart attack
- ❑ Unexplained weight loss
- ❑ Angina
- ❑ Cancer of _____
- ❑ Irregular heartbeat
- ❑ Other tumor _____
- ❑ Other heart problems
- ❑ Blood transfusions
- ❑ Rheumatic fever
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ AIDS/HIV
- ❑ Meningitis
- ❑ Other illnesses, please specify:_____

38. Do any blood relatives have:

- ❑ Diabetes
- ❑ Cancer
- ❑ Hypoglycemia
- ❑ Heart disease
- ❑ Other major medical problems such as those above: (please specify)

_____

39. Describe serious accidents <u>unless</u> directly related to your doctor's visit here.

- ❑ None
- ❑ Occurred with head injury, loss of consciousness, or whiplash
- ❑ Occurred without head injury, loss of consciousness, or whiplash. Describe:_____

40. List all current medications and doses (include birth control pills and vitamins)

_____

_____

_____

41. Please list medication allergies:

- ❑ Novocaine
- ❑ Penicillin
- ❑ Iodine
- ❑ Sulfa
- ❑ Codeine
- ❑ None known
- ❑ Keflex/Ceclor/Ceftin
- ❑ X-ray dyes
- ❑ Latex
- ❑ Other (please specify):_____

43. Please list operations:

- ❑ Tonsillectomy (age ____)
- ❑ Adenoidectomy (age _____)
- ❑ Appendectomy (age ____)
- ❑ Heart Surgery (age _____)
- ❑ Other, please specify:

48. Have you had X-ray or radiation treatments to your head or neck (including treatments for acne or ear problems as a child, treatments for cancer, etc.)

- ❑ Yes
- ❑ No