PATIENT HISTORY : VOICE QUESTIONNAIRE

Name:_____ Age: ____ Sex: ___ Date: _____
Height: _____ Weight: _____ Ethnic background _____

PLEASE CHECK OR CIRCLE CORRECT ANSWERS

1. How long have you had your present voice problem?_____
   Who noticed it?_____
   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
   Change during the day ❑yes ❑no ❍better ❍worse
   Change with emotions ❑yes ❑no ❍better ❍worse

2. Which symptoms do you have? **(Please check all that apply.)**
   - ❑ Hoarseness (coarse or scratchy sound)
   - ❑ Fatigue (voice tires or changes quality after using it for a short period of time)
   - ❑ Volume disturbances (trouble speaking) softly_____ loudly_____
   - ❑ Loss of range (high_____ low_____)
   - ❑ Breathiness
   - ❑ Voice just cuts out
   - ❑ Tickling or choking sensation while speaking
   - ❑ Pain in throat after speaking
   - ❑ Other_____

3. Employment:
   - ❑ Actor
   - ❑ Athletic Instructor
   - ❑ Clergy
   - ❑ Sales Person
   - ❑ Telephone Operator
   - ❑ Server
   - ❑ Announcer(TV/radio/sports)
   - ❑ Attorney
   - ❑ Telemarketing Agent
   - ❑ Educator
   - ❑ Receptionist
   - ❑ Administrative Assistant
   - ❑ Other_____

4. 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	☐	☐	☐

5. Please check all that apply to you:

- ❑ Cheerleader past or present
- ❑ Speak extensively at parties or with friends
- ❑ Bitter or acid taste, or bad breath first thing in the morning
- ❑ Frequent yelling or loud talking
- ❑ Frequent whispering
- ❑ Chronic fatigue (insomnia)
- ❑ Work around extreme dryness, smoke, or fumes
- ❑ Frequently thirsty, dehydrated
- ❑ Ever used antacids
- ❑ Under particular stress at present (personal or professional)
- ❑ Frequent bad breath
- ❑ Traveled recently: When: _____ Where:_____

6. Do you often eat/drink/consume?

❑ Caffeine ❑ Chocolate ❑ Dairy products ❑ Spicy foods
❑ Alcohol ❑ Nuts ❑ Large portions ❑ Recreational drugs

7. 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:_____

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

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

10. 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

11. Please list any recreational drugs you use: ❑ None
❑ Amphetamines ❑ Cocaine ❑ Marijuana
❑ Heroin ❑ Ecstasy ❑ Other_____

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

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

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

15. Have you noticed any of the following? (Please check all that apply.)

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

16. *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? _____

17. Are you involved in legal action involving problems with your voice?

❑Yes ❑ No

18. 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)_____

19. 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:_____

20. Do any blood relatives have:

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

21. Describe serious accidents in the past.

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

22. List all current medications and doses (include birth control pills, vitamins and herbs)

_____
_____
_____

23. Please list medication allergies:

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

24. Please list operations:

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

25. 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

26. Have you ever had training for your speaking voice? ❑ Yes ❑ No
Acting voice lessons? ❑ Yes ❑ No
How long?_____
Speech therapy? ❑ Yes ❑ No
How long?_____

27. Do you play a musical instrument(s)? ❑ Yes ❑ No
If yes, which one(s)_____