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### PATIENT HISTORY: SINGERS

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ ETHNIC ORIGIN \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DATE \_\_\_\_\_

VOICE CATEGORY: \_\_\_\_\_ soprano \_\_\_\_\_ mezzo soprano \_\_\_\_\_ alto  
\_\_\_\_\_ tenor \_\_\_\_\_ baritone \_\_\_\_\_ bass

(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, family, voice teacher, critics, everyone, 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 \_\_\_\_\_, or 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 disturbance (trouble singing) softly \_\_\_\_\_ loudly \_\_\_\_\_  
Loss of range (high \_\_\_\_\_ low \_\_\_\_\_)  
Change in classification (example: voice lowered from soprano to mezzo)  
Prolonged warm-up time (over 1/2 hrs. to warm up voice)  
Breathiness  
Tickling or choking sensation while singing  
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 your long term career goals in singing?  
[ ] Premiere operatic career  
[ ] Premiere pop music career  
[ ] Active avocation  
[ ] Classical  
[ ] Pop  
[ ] Other [ \_\_\_\_\_ ]  
[ ] Amateur performance (choral or solo) [ ] Amateur  
singing for own pleasure
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 previous teachers and years during which you studied with them:
10. Have you ever had training for your speaking voice? Yes \_\_\_\_\_ No \_\_\_\_\_  
Acting voice lessons? Yes \_\_\_\_\_ No \_\_\_\_\_
- How many years?  
Speech therapy? Yes \_\_\_\_\_ No \_\_\_\_\_  
How many months? \_\_\_\_\_
11. Do you have a job in addition to singing?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- If yes, does it involve extensive voice use?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what is it? [actor, announcer (television/radio/sports arena), athletic instructor, attorney, clergy, politician, physician, sales person, stock broker, teacher, telephone operator or receptionist, waiter, waitress, secretary, other \_\_\_\_\_ ]
12. In your performance work, in addition to singing, are you frequently required to speak? Yes \_\_\_\_\_ No \_\_\_\_\_  
dance? Yes \_\_\_\_\_ No \_\_\_\_\_
13. How many years did you sing actively before beginning voice lessons initially?
14. What types of music do you sing? (Check all that apply.)  
Classical \_\_\_\_\_ Show \_\_\_\_\_  
Night Club \_\_\_\_\_ Rock \_\_\_\_\_  
Other: (Please specify) \_\_\_\_\_
15. Do you regularly sing in a sitting position (such as from behind a piano or drum set)? Yes \_\_\_\_\_ No \_\_\_\_\_
16. Do you sing outdoors or in large halls, or with orchestras? (Circle which **one**.) Yes \_\_\_\_\_ No \_\_\_\_\_
17. If you perform with electrical instruments or outdoors do you use monitor speakers? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, can you hear them? Yes \_\_\_\_\_ No \_\_\_\_\_
18. 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  
\_\_\_\_ Wind with single reed  
\_\_\_\_ Wind with double reed  
\_\_\_\_ Flute, Piccolo  
\_\_\_\_ Percussion  
\_\_\_\_ Bagpipe  
\_\_\_\_ Accordion  
\_\_\_\_ Other (Please specify): \_\_\_\_\_
19. 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?  
[ 15, 30, 45, 60, 75, 90, 105, 120, more ] minutes  
Songs: [ daily, few times weekly, once a week, rarely, never ]  
How many hours per day?  
[ 1/2, 1, 1 1/2, 2, 2 1/2, 3, more ]  
Do you warm-up your voice before you sing? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you warm-down your voice when your finished singing? Yes \_\_\_\_\_ No \_\_\_\_\_
20. How much are you singing at present (total including practice time) (average hours per day )?

Rehearsal:  
Performance:

21. Please check all that apply to you:

- Voice worse in the morning
- Voice worse later in the day, after it has been used.
- Sing performances or rehearsals in the morning
- Speak extensively (e.g., teacher, clergy, attorney, telephone, work, etc. )
- Cheerleader
- Speak extensively backstage or at post-performance parties
- Choral conductor
- Frequently clear your throat
- Frequent sore throat
- Jaw joint problems
- Bitter or acid taste, or bad breath first thing in the morning
- Frequent "heartburn"
- Hiatal hernia
- Frequent yelling/loud talking
- Frequent whispering
- Chronic fatigue
- Insomnia
- Work in extreme dryness
- Frequent exercise, (weight lifting, aerobics, etc. )
- Frequently thirsty, dehydrated
- Hoarseness in the morning
- Chest cough
- 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: \_\_\_\_\_

Eat any of the following before singing?

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Coffee            |
| <input type="checkbox"/> Alcohol   | <input type="checkbox"/> Milk or ice cream |
| <input type="checkbox"/> Nuts      | <input type="checkbox"/> Spiced foods      |

Other ( Please specify):

Any specific vocal technical difficulties?

[ **trouble singing soft, trouble singing loud, poor pitch control, support problems, problems at register transitions, other** ] Describe other:

Any problems with your singing voice recently prior to the onset of the problem that brought you here?

[ **hoarseness, breathiness, fatigue, loss of range, voice breaks, pain singing, other** ] Describe others:

Any Voice problems in the past that required a visit to a physician? If yes, please describe problem (s) and treatment (s):

[ **laryngitis, nodules, polyps, hemorrhage, cancer, other** ] Describe other:

22. Your family doctor's name, address and telephone number.

23. Your laryngologist's name, address and telephone number.

- |                   |     |    |
|-------------------|-----|----|
| 24. Recent cold?  | Yes | No |
| 25. Current cold? | Yes | No |

26. Have you been exposed to any of the following chemicals frequently (or recently) at home or at work:

Carbon Monoxide       Insecticides       Stage Smoke  
 Mercury       Lead       Arsenic  
 Aniline dyes       Industrial solvents (benzene, etc.)

27. Have you been evaluated by an allergist?      Yes      No

If yes, what allergies do you have?

[ **none, dust, mold, trees, cats, dog, foods, other,** \_\_\_\_\_ ( Medication allergies are covered elsewhere in this history form. )

If yes, give name and address of allergist

28. Do you smoke cigarettes or use other forms of tobacco?

Never

Quit. When? \_\_\_\_\_ Smoked about \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Smoke \_\_\_\_\_ packs per day. Have smoked for \_\_\_\_\_ years.

Use other forms of tobacco. Circle which: **Pipe Cigar Chewing Tobacco Other**

29. Do you live or work in a smoky environment?

Yes \_\_\_\_\_ No \_\_\_\_\_

30. How much alcohol do you drink?

None

Number of Glasses of Beer, wine, Liquor (**circle which**) \_\_\_\_\_ number of times per week/month/year (**circle which**)

Did you use to drink more heavily?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had difficulty with alcohol abuse?

Yes \_\_\_\_\_ No \_\_\_\_\_

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

32. Have you ever used any recreational drugs?

**marijuana**     **cocaine**     **amphetamines**     **barbiturates**     **heroin**     **other**  
(explain)

Are you currently using any of these? If so, which and how often?

33. 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

For females:

Are you pregnant?

Yes

No

Are your menstrual periods regular?

Yes

No

Have you undergone 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?

34. Have you ever consulted a psychologist or psychiatrist? Yes No  
 Are you currently under treatment? Yes No  
 35. Have you injured your head or neck (whiplash, etc. )? Yes No  
 36. Describe any serious accidents related to this visit. None \_\_\_\_\_  
 37. Are you involved in legal action involving problems with your voice? Yes No  
 38. List names of spouse and children:

39. Brief summary of ENT problems, some of which may not be related to your present complaint.

**PLEASE CHECK ALL THAT APPLY**

41. \_\_\_\_\_Hearing loss \_\_\_\_\_Ear pain  
 \_\_\_\_\_Ear noises \_\_\_\_\_Facial pain  
 \_\_\_\_\_Dizziness \_\_\_\_\_Stiff neck  
 \_\_\_\_\_Facial paralysis \_\_\_\_\_Lump in neck  
 \_\_\_\_\_Nasal obstruction \_\_\_\_\_Lump in face or head  
 \_\_\_\_\_Nasal deformity \_\_\_\_\_Trouble swallowing  
 \_\_\_\_\_Mouth sores \_\_\_\_\_Excess eye skin  
 \_\_\_\_\_Jaw joint problem \_\_\_\_\_Excess facial skin  
 \_\_\_\_\_Eye problem \_\_\_\_\_Other: ( Please specify )

40. Do you have or have you ever had:  
 \_\_\_\_\_Diabetes \_\_\_\_\_Seizures  
 \_\_\_\_\_Hypoglycemia \_\_\_\_\_Psych. therapy  
 \_\_\_\_\_Thyroid problems \_\_\_\_\_Syphilis  
 \_\_\_\_\_Gonorrhea \_\_\_\_\_Herpes  
 \_\_\_\_\_Cold sores ( fever blisters) \_\_\_\_\_High blood pressure  
 \_\_\_\_\_Severe low blood pressure \_\_\_\_\_Intravenous antibiotics  
 \_\_\_\_\_Diuretics \_\_\_\_\_Heart attack  
 \_\_\_\_\_Angina \_\_\_\_\_Irregular heartbeat  
 \_\_\_\_\_Other heart problems \_\_\_\_\_Rheumatic fever  
 \_\_\_\_\_Tuberculosis \_\_\_\_\_Glaucoma  
 \_\_\_\_\_Multiple sclerosis \_\_\_\_\_Frequent bad headaches  
 \_\_\_\_\_Ulcers \_\_\_\_\_Kidney disease  
 \_\_\_\_\_Urinary problems \_\_\_\_\_Arthritis or skeletal problems  
 \_\_\_\_\_Cleft palate \_\_\_\_\_Asthma  
 \_\_\_\_\_Lung or breathing problems \_\_\_\_\_Unexplained  
 weight loss  
 \_\_\_\_\_Cancer of ( \_\_\_\_\_ )  
 \_\_\_\_\_Other tumor ( \_\_\_\_\_ )

41. Do any blood relatives have:  
 \_\_\_\_\_Diabetes \_\_\_\_\_Cancer  
 \_\_\_\_\_Hypoglycemia \_\_\_\_\_Heart disease  
 Other major medical problems such as those above. Please specify:

42. Describe serious accidents unless directly related to your doctor's visit here.  
 \_\_\_\_\_None  
 \_\_\_\_\_Occur'ed with head injury, loss of consciousness or whiplash  
 \_\_\_\_\_Occurred without head injury, loss of consciousness or whiplash Describe:  
 43. List all current medications and doses ( include birth control pills and vitamins ).

44. Medication allergies
- |   |  |
|---|--|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Novocaine     |
| <input type="checkbox"/> Penicillin               | <input type="checkbox"/> Iodine        |
| <input type="checkbox"/> Sulfa                    | <input type="checkbox"/> Codeine       |
| <input type="checkbox"/> Tetracycline             | <input type="checkbox"/> Adhesive tape |
| <input type="checkbox"/> Erythromycin             | <input type="checkbox"/> Aspirin       |
| <input type="checkbox"/> Keflex / Ceclor / Ceftin | <input type="checkbox"/> X-ray dyes    |
| <input type="checkbox"/> Other, please specify:   |  |
45. List operations
- |                           |                             |
|---------------------------|-----------------------------|
| Tonsillectomy (age _____) | Adenoidectomy ( age _____ ) |
| Appendectomy ( age _____) | Heart surgery ( age _____ ) |
| Other. Please specify:    |                             |
46. List toxic drugs or chemicals to which you have been exposed:
- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Lead      | <input type="checkbox"/> Streptomycin, Neomycin, |
| <input type="checkbox"/> Kanamycin | <input type="checkbox"/> Other. Please specify:  |
| <input type="checkbox"/> Mercury   |  |
47. Have you had x-ray treatments to you head or neck (including treatments for acne or ear problems as a child) treatments for cancer, etc.) ? Yes No
- 48.
49. Describe serious health problems of your spouse or children. \_\_\_\_\_ None