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### PATIENT HISTORY: VOICE

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

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

1. How long have you had your present voice problem? \_\_\_\_\_ Who noticed it?  
Do you know what caused it? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
If so, 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 speaking for a short period of time)  
\_\_\_\_\_ Volume disturbance (trouble speaking) softly \_\_\_\_\_  
loudly \_\_\_\_\_  
\_\_\_\_\_ Loss of range (high \_\_\_\_\_, low \_\_\_\_\_)  
\_\_\_\_\_ Prolonged warm-up time (over 1/2 hrs. to warm up voice)  
\_\_\_\_\_ Breathiness  
\_\_\_\_\_ Tickling or choking sensation while speaking  
\_\_\_\_\_ Pain in throat while speaking  
\_\_\_\_\_ Other (Please specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had training for your speaking voice?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_
4. Have there been periods of months or years without lessons in that time?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_
5. How long have you studied with your present teacher?  
Teacher's name:  
  
Teacher's address:  
  
Teacher's telephone number:
6. Please list previous teachers and years during which you studied with them:
7. Have you ever had training for your singing voice?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
If so, list teachers and years of study:
8. In what capacity do you use your voice professionally?  
\_\_\_\_\_ Actor  
\_\_\_\_\_ Announcer (television/radio/sports arena)  
\_\_\_\_\_ Attorney  
\_\_\_\_\_ Clergy  
\_\_\_\_\_ Politician  
\_\_\_\_\_ Salesperson  
\_\_\_\_\_ Teacher  
\_\_\_\_\_ Telephone operator or receptionist  
\_\_\_\_\_ Other (Please specify): \_\_\_\_\_

9. Do you have an important performance soon? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_  
Date(s): \_\_\_\_\_
10. Do you do regular voice exercises? **Yes** \_\_\_\_\_ **No** If yes,  
describe: \_\_\_\_\_
11. Do you play a musical instrument? **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): \_\_\_\_\_
12. Do you warm-up your voice before practice or performance?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_
- Do you warm-down after using it?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_
13. How much are you speaking at present (average hours per day)?  
 Rehearsal \_\_\_\_\_  Performance \_\_\_\_\_  Other \_\_\_\_\_
14. 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; bad breath or hoarseness 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  
 Hoarseness first thing 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: \_\_\_\_\_
15. Your family doctor's name, address and telephone number: \_\_\_\_\_

16. Your laryngologist's name, address and telephone number:

17. Recent cold? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

18. Current cold? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

19. 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:

20. 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**

21. Do you live or work in a smoky environment? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

22. 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** \_\_\_\_\_

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

24. 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?

25. 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 your voice

\_\_\_\_\_ 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 (When?) \_\_\_\_\_ No \_\_\_\_\_

26. Have you ever consulted a psychologist or psychiatrist?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

For what reason? \_\_\_\_\_

Are you currently under treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

27. Have you injured your head or neck -(whiplash, etc.)?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

28. Describe any serious accidents related to this visit.  
Details of Accident: \_\_\_\_\_

\_\_\_\_\_ None

29. Are you involved in legal action involving problems with your voice?  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

30. List names of spouse and children:

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

- |                               |                            |
|-------------------------------|----------------------------|
| _____ 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   |
| _____ Nose bleeds             | _____ Trouble breathing    |
| _____ Mouth sores             | _____ Excess eye skin      |
| _____ Excess facial skin      | _____ Eye problem          |
| _____ Jaw joint problem       |                            |
| _____ Other (Please specify): |                            |

32. Do you have or have you ever had:

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Hypoglycemia                            | <input type="checkbox"/> Psych. therapy                 |
| <input type="checkbox"/> Thyroid problems                        | <input type="checkbox"/> Frequent bad headaches         |
| <input type="checkbox"/> Syphilis                                | <input type="checkbox"/> Ulcers                         |
| <input type="checkbox"/> Gonorrhea                               | <input type="checkbox"/> Kidney disease                 |
| <input type="checkbox"/> Herpes                                  | <input type="checkbox"/> Urinary problems               |
| <input type="checkbox"/> Cold sores (fever blisters)             | <input type="checkbox"/> Arthritis or skeletal problems |
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Cleft palate                   |
| <input type="checkbox"/> Severe low blood pressure               | <input type="checkbox"/> Asthma                         |
| <input type="checkbox"/> Intravenous antibiotics<br>or diuretics | <input type="checkbox"/> Lung or breathing problems     |
| <input type="checkbox"/> Heart attack                            | <input type="checkbox"/> Unexplained weight loss        |
| <input type="checkbox"/> Angina                                  | <input type="checkbox"/> Cancer of (_____)              |
| <input type="checkbox"/> Irregular heartbeat                     | <input type="checkbox"/> Other tumor (_____)            |
| <input type="checkbox"/> Other heart problems                    | <input type="checkbox"/> Blood transfusions             |
| <input type="checkbox"/> Rheumatic fever                         | <input type="checkbox"/> Hepatitis                      |
| <input type="checkbox"/> Tuberculosis                            | <input type="checkbox"/> AIDS                           |
| <input type="checkbox"/> Glaucoma                                | <input type="checkbox"/> Meningitis                     |
| <input type="checkbox"/> Multiple sclerosis                      |   |
| <input type="checkbox"/> Other illnesses ,(Please specify):      |   |

33. Do any blood relatives have:

- |   |  |
|---|--|
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Hypoglycemia  |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Other major medical problems |  |
| Please specify:                                       |  |

34. Describe serious accidents unless 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:

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

36. Medication allergies

- |  |               |
|--|---------------|
| <input type="checkbox"/> None                    | Novocaine     |
| <input type="checkbox"/> Penicillin              | Iodine        |
| <input type="checkbox"/> Sulfa                   | Codeine       |
| <input type="checkbox"/> Tetracycline            | Adhesive tape |
| <input type="checkbox"/> Erythromycin            | Aspirin       |
| <input type="checkbox"/> Keflex/Ceclor/Ceftin    | X-ray dyes    |
| <input type="checkbox"/> Other (Please specify): |               |

37. List operations:

- |  |                            |
|--|----------------------------|
| <input type="checkbox"/> Tonsillectomy (age _____) | _____ Adenoidectomy (age ) |
| <input type="checkbox"/> Appendectomy (age _____)  | _____ Heart surgery (age ) |
| <input type="checkbox"/> Other: (Please specify)   |                            |

