

## Indiana University Voice Clinic Patient History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Referring Physician/Instructor: \_\_\_\_\_

### Description of Current Voice Problem

#### Onset/Development/Etiology

How would you describe your voice problem? \_\_\_\_\_  
\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Who noticed it? \_\_\_\_\_

How long did it take to develop? \_\_\_\_\_

Did it develop slowly or suddenly? \_\_\_\_\_

Is it getting: Worse \_\_\_\_\_ Better \_\_\_\_\_ Staying the same \_\_\_\_\_

#### Cause

What do you think caused this voice problem? \_\_\_\_\_

Does it vary in severity? \_\_\_\_\_

Does it vary during the day? \_\_\_\_\_

What time of day is your voice best? Worst? \_\_\_\_\_

#### Vocal Quality

Which of the following symptoms do you currently have?

- \_\_\_\_\_ Breathiness
- \_\_\_\_\_ Hoarseness (coarse or scratchy sound)
- \_\_\_\_\_ Fatigue (voice tires or changes quality after short periods of use)
- \_\_\_\_\_ Difficulty speaking softly \_\_\_\_\_ or loudly \_\_\_\_\_
- \_\_\_\_\_ Loss of range, high \_\_\_\_\_, low \_\_\_\_\_, or middle \_\_\_\_\_
- \_\_\_\_\_ Tickling or choking sensation while using voice
- \_\_\_\_\_ Pain in throat while using voice
- \_\_\_\_\_ Voice is worse in the morning
- \_\_\_\_\_ Voice is worse later in the day, after it has been used
- \_\_\_\_\_ Frequently clear throat
- \_\_\_\_\_ Bitter or acid taste
- \_\_\_\_\_ Bad breath in the morning
- \_\_\_\_\_ Hoarseness first thing in the morning
- \_\_\_\_\_ Laryngitis more than twice a year

- \_\_\_\_\_ Increased effort to talk
  - \_\_\_\_\_ Breathing difficulties
  - \_\_\_\_\_ Swallowing difficulties
  - \_\_\_\_\_ Choking sensation when not using voice
  - \_\_\_\_\_ Voice strain
  - \_\_\_\_\_ Pain in jaw associated with Temporal Mandibular Joint Dysfunction
  - \_\_\_\_\_ Other symptoms (please describe) \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Treatment

Have you ever had treatment for your voice? Where and when? \_\_\_\_\_

What type of treatment was done? \_\_\_\_\_

Did your voice improve? For how long? \_\_\_\_\_

Was treatment stopped? Why? \_\_\_\_\_

Describe any specific vocal technical difficulties not already mentioned. \_\_\_\_\_

\_\_\_\_\_

Describe any problems with your voice prior to the onset of the problem that brought you here. \_\_\_\_\_

\_\_\_\_\_

Describe any voice problems in the past that required a visit to a physician. Describe any past treatment(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Background Information**

Family Background

Is your voice similar to anyone else's in your family? Describe. \_\_\_\_\_

\_\_\_\_\_

Are there any other voice or speech problems in your family? \_\_\_\_\_

Do people in your family talk a lot? \_\_\_\_\_ Loudly? \_\_\_\_\_

Educational/Occupational History

Last school attended /Where /Grade completed: \_\_\_\_\_

Name and address of most recent employer: \_\_\_\_\_

\_\_\_\_\_

What is your occupation? If retired, describe former occupation. \_\_\_\_\_

\_\_\_\_\_

How long have you been or were you employed? \_\_\_\_\_

**Medical History**

Your primary care physician's name, address, fax and telephone numbers: \_\_\_\_\_

Your otolaryngologist's name, address, fax and telephone numbers: \_\_\_\_\_

Have you ever been evaluated by an allergist? Yes \_\_\_ No \_\_\_ If yes, please give name, address and test results. \_\_\_\_\_

Are you allergic to any medicines? If so, please list: \_\_\_\_\_

Have you ever consulted a psychologist or psychiatrist? \_\_\_\_\_

Have you had a cold recently? Yes \_\_\_ No \_\_\_ If yes, please list any symptoms that are still present. \_\_\_\_\_

Have you had x-ray treatments to your head, neck or face? \_\_\_\_\_

Have you ever injured your head or neck (e.g., whiplash)? \_\_\_\_\_

Have you been exposed to any of the following toxic drugs or chemicals?

\_\_\_ Insecticides \_\_\_ Lead \_\_\_ Industrial solvents (benzene, etc.)

\_\_\_ Mercury \_\_\_ Streptomycin, Neomycin, Kanamycin

\_\_\_ Other (Please list.)

How many packs of cigarettes do or did you smoke per day, and for how many years?

Does your spouse or roommate smoke? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_ Did you used to drink more heavily? \_\_\_\_\_

How many cups of coffee or other caffeine-containing drinks do you consume per day?

List any other drugs you use or have used. \_\_\_\_\_

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

- |                                      |   |
|--------------------------------------|---|
| ___ Hypersensitivity to heat or cold | ___ Excessive sweating                  |
| ___ Change in skin or hair           | ___ Change in weight: gained/lost _____ |
| ___ Palpitation of the heart         | lbs in ___ weeks ___ months             |
| ___ Emotional lability (mood swings) | ___ Double vision                       |
| ___ Blurred vision or blindness      | ___ Numbness of face or extremities     |
| ___ Tingling around mouth or face    | ___ Weakness/paralysis of face          |
| ___ Clumsiness of arms or legs       | ___ Confusion or loss of memory         |
| ___ Difficulty with speech           | ___ Difficulty with swallowing          |
| ___ Seizures                         | ___ Neck or shoulder pain               |
| ___ Shaking or tremors               | ___ Memory change                       |
| ___ Personality change               |   |

Describe any treatments for the above. \_\_\_\_\_

Check any of the following ear, nose and throat (ENT) problems you have experienced, some of which may not be related to your present complaint.

- |  |   |
|--|---|
| <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Ear pain             |
| <input type="checkbox"/> Ear noises              | <input type="checkbox"/> Facial pain          |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Stiff neck           |
| <input type="checkbox"/> Facial paralysis        | <input type="checkbox"/> Lump in neck         |
| <input type="checkbox"/> Nasal obstruction       | <input type="checkbox"/> Lump in face or head |
| <input type="checkbox"/> Nose bleeds             | <input type="checkbox"/> Trouble swallowing   |
| <input type="checkbox"/> Mouth sores             | <input type="checkbox"/> Trouble breathing    |
| <input type="checkbox"/> Excess facial skin      | <input type="checkbox"/> Excess eye skin      |
| <input type="checkbox"/> Jaw joint problem       | <input type="checkbox"/> Eye problem          |
| <input type="checkbox"/> Other (Please specify.) |   |

Do you have or have you ever had:

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Hypoglycemia                         | <input type="checkbox"/> Psychiatric 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 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.)   |   |

List any medications you currently take, along with their dosages (include birth control pills and vitamins). \_\_\_\_\_

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"/> Erythromycin |
| <input type="checkbox"/> Keflex/Ceclor/Ceftin     | <input type="checkbox"/> Aspirin      |
| <input type="checkbox"/> Other: (Please specify.) |                                       |

At what age did you reach puberty? \_\_\_\_\_

***For females:***

Are you pregnant?

Are your menstrual periods regular?

Do you notice changes in your voice during your menstrual periods?

If so, describe. \_\_\_\_\_

Have you undergone hysterectomy?

Were your ovaries removed?

Have you gone through menopause?

If yes, when?

**Vocal Characteristics/Lifestyle Habits**

Which of the following apply to you? (Check any amount)

\_\_\_\_\_ I speak extensively

\_\_\_\_\_ I have a history of cheerleading

\_\_\_\_\_ I talk frequently at parties or in large groups

\_\_\_\_\_ I often eat late at night

\_\_\_\_\_ I use antacids often

\_\_\_\_\_ I am under particular stress at present (personal and/or professional)

\_\_\_\_\_ I live or work around cigarette smoke or fumes

\_\_\_\_\_ I traveled recently; When: \_\_\_\_\_ Where: \_\_\_\_\_

I often eat the following:      Chocolate \_\_\_\_\_      Spicy foods \_\_\_\_\_      Nuts \_\_\_\_\_  
   Milk or ice cream \_\_\_\_\_      Coffee \_\_\_\_\_      Alcohol \_\_\_\_\_

I drink approximately \_\_\_\_\_ glasses of water each day.

Describe a typical day of voice use. \_\_\_\_\_

\_\_\_\_\_

**Billing Information**

Who is responsible for your bills?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relation to you: \_\_\_\_\_

Please be advised that we accept payments in cash, check or credit card, but we cannot bill to the IU bursar.