

PATIENT HISTORY: PROFESSIONAL VOICE USERS

NAME _____ AGE _____ SEX _____ RACE _____
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 _____ 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)
_____ 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 _____ Dates: _____

10. Do you do regular voice exercises? Yes _____ No _____ If yes, describe: _____

11. Do you play a musical instrument? Yes _____ No _____ If yes, 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
- 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
- Frequently have a 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 round 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 _____ Current Cold? Yes _____ No _____

18. 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 form.) If yes, give name and address of allergist:

-
19. How many packs of cigarettes do you smoke per day? _____
Smoking History
____ Never
____ Quit. When _____
____ Smoked about _____ packs per day for _____ years.
____ Smoke _____ packs per day. Have smoked for _____ years.
20. Do you live or work in a smokey environment? Yes _____ No _____
21. How much alcohol do you drink? (none, rarely, a few times per week, daily) If daily, or few times per week, on the average, how much do you consume? (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, more) glasses per (day, week) of (beer, wine, liquor) Did you use to drink more heavily? Yes _____ No _____
23. How many cups of coffee, tea, cola or other caffeine-containing drinks do you drink per day? _____
24. List other recreational drugs you use (**marijuana, cocaine, amphetamines, barbiturates, heroin, other _____**)
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? | YES _____ | NO _____ |
| Have you gone through menopause? | YES _____ | NO _____ |
26. Have you ever consulted a psychologist or psychiatrist?
YES _____ NO _____
- | | | |
|------------------------------------|-----------|----------|
| 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:

- | | |
|--|---|
| _____ Diabetes | _____ Seizures |
| _____ Hypoglycemia | _____ Psych. Therapy |
| _____ Thyroid problems | _____ Frequent bad headaches |
| _____ Syphilis | _____ Ulcers |
| _____ Gonorrhea | _____ Kidney disease |
| _____ Herpes | _____ Urinary problems |
| _____ Cold sores (fever blisters) | _____ Arthritis or skeletal problems |
| _____ High blood pressure | _____ Cleft palate |
| _____ Severe low blood pressure | _____ Asthma |
| _____ Intravenous antibiotics or diuretics | _____ 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 |
| _____ Glaucoma | _____ Meningitis |
| _____ Multiple sclerosis | _____ Other illnesses (please specify): |

33. Do any blood relatives have:

- | | |
|---|---------------------|
| _____ Diabetes | _____ Cancer |
| _____ Hypoglycemia | _____ Heart disease |
| _____ Other major medical problems such as those above. | |
| 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 | <input type="checkbox"/> Novacaine |
| <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): | |

37. List operations:

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

38. List toxic drugs or chemicals to which you have been exposed:

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Lead | <input type="checkbox"/> Streptomycin, Neomycin, Kanamycin |
| <input type="checkbox"/> Mercury | <input type="checkbox"/> Other (please list): |

39. Have you had x-ray treatment to your head or neck (including treatments for acne or ear problems as a child), treatments for cancer, etc.?

YES _____ NO _____

40. Describe serious health problems of your spouse or children.

_____ None