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 ½ 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 specifiy):

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

_____None
_____ Penicillin
_____ Sulfa
_____ Tetracycline
_____ Erythromycin
_____ Keflex/Ceclor/Ceftin
_____ Other (please specify):

_____ Novacaine
_____ Iodine
_____ Codeine
_____ Adhesive tape
_____ Aspirin
_____ X-ray dyes

37. List operations:

_____ Tonsillectomy (age _____)
_____ Appendectomy (age _____)
_____ Other (Please specify):

_____Adenoidectomy (age_____)
_____ Heart surgery (age _____)

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

_____ Lead
_____ Mercury

_____ Streptomycin, Neomycin, Kanamycin
_____ 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