

# PATIENT HISTORY : VOICE QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Ethnic background \_\_\_\_\_

## PLEASE CHECK OR CIRCLE CORRECT ANSWERS

1. How long have you had your present voice problem? \_\_\_\_\_

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

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  same

Change during the day  yes  no  better  worse

Change with emotions  yes  no  better  worse

2. Which symptoms do you have? **(Please check all that apply.)**

- Hoarseness (coarse or scratchy sound)
- Fatigue (voice tires or changes quality after using it for a short period of time)
- Volume disturbances (trouble speaking) softly \_\_\_\_\_ loudly \_\_\_\_\_
- Loss of range ( high \_\_\_\_\_ low \_\_\_\_\_)
- Breathiness
- Voice just cuts out
- Tickling or choking sensation while speaking
- Pain in throat after speaking
- Other (please specify) \_\_\_\_\_

3. Employment

- Actor  announcer(TV/radio/sports)
- athletic instructor  attorney
- clergy  telemarketing agent
- sales person  educator
- telephone operator  receptionist
- server  administrative assistant
- other \_\_\_\_\_

4. Which of these are present in your daily voice use?

	OFTEN	SOMETIMES	NEVER
Talking in a noisy environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shouting, screaming, yelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat-clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Please check all that apply to you:

- Cheerleader past or present
- Speak extensively at parties or with friends



15. Have you noticed any of the following? (Please check all that apply.)

- |  |  |
|--|--|
| <input type="checkbox"/> Hypersensitivity to heat or cold                                | <input type="checkbox"/> Excessive sweating                    |
| <input type="checkbox"/> Change in skin or hair  | <input type="checkbox"/> Palpitation (fluttering) of the heart |
| <input type="checkbox"/> Emotional lability (swings of mood)                             | <input type="checkbox"/> Double vision                         |
| <input type="checkbox"/> Numbness of the face or extremities                             | <input type="checkbox"/> Tingling around the mouth or face     |
| <input type="checkbox"/> Blurred vision or blindness                                     | <input type="checkbox"/> Weakness or paralysis of the face     |
| <input type="checkbox"/> Clumsiness in arms or legs                                      | <input type="checkbox"/> Confusion or loss of consciousness    |
| <input type="checkbox"/> Difficulty with speech  | <input type="checkbox"/> Difficulty with swallowing            |
| <input type="checkbox"/> Seizure (epileptic fit)   | <input type="checkbox"/> Pain in the neck or shoulder          |
| <input type="checkbox"/> Shaking or tremors  | <input type="checkbox"/> Memory change                         |
| <input type="checkbox"/> Personality change  |  |
| <input type="checkbox"/> Change in weight: gained/lost _____ lbs. in _____ weeks/months. |  |

16. **For females:**

- Are you pregnant?  Yes  No
- Are your menstrual periods regular?  Yes  No
- Have you undergone a 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? \_\_\_\_\_

17. Are you involved in legal action involving problems with your voice?  
 Yes  No

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

*PLEASE CHECK ALL THAT APPLY*

- |  |  |
|--|--|
| <input type="checkbox"/> Hearing loss      |  |
| <input type="checkbox"/> Ear pain          | <input type="checkbox"/> Nasal deformity               |
| <input type="checkbox"/> Ear noises        | <input type="checkbox"/> Trouble swallowing            |
| <input type="checkbox"/> Facial pain       | <input type="checkbox"/> Mouth sores                   |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw joint problem             |
| <input type="checkbox"/> Stiff neck        | <input type="checkbox"/> Excess facial skin            |
| <input type="checkbox"/> Facial paralysis  | <input type="checkbox"/> Eye problem                   |
| <input type="checkbox"/> Lump in neck      | <input type="checkbox"/> Other: (please specify) _____ |
| <input type="checkbox"/> Nasal obstruction |  |

19. Do you have or have you ever had:

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Arthritis or skeletal problems |
| <input type="checkbox"/> Seizures                    | <input type="checkbox"/> High blood pressure            |
| <input type="checkbox"/> Hypoglycemia                | <input type="checkbox"/> Cleft palate                   |
| <input type="checkbox"/> Psych. therapy              | <input type="checkbox"/> Asthma                         |
| <input type="checkbox"/> Thyroid problems            | <input type="checkbox"/> Lung or breathing problems     |
| <input type="checkbox"/> Frequent bad headaches      | <input type="checkbox"/> Heart attack                   |
| <input type="checkbox"/> Syphilis                    | <input type="checkbox"/> Unexplained weight loss        |
| <input type="checkbox"/> Kidney disease              | <input type="checkbox"/> Angina                         |
| <input type="checkbox"/> Cold sores (fever blisters) | <input type="checkbox"/> Cancer of _____                |

- |   |  |
|---|--|
| <input type="checkbox"/> Irregular heartbeat  | <input type="checkbox"/> Tuberculosis                              |
| <input type="checkbox"/> Other tumor _____    | <input type="checkbox"/> AIDS/HIV                                  |
| <input type="checkbox"/> Other heart problems | <input type="checkbox"/> Meningitis                                |
| <input type="checkbox"/> Blood transfusions   | <input type="checkbox"/> Other illnesses, please<br>specify: _____ |
| <input type="checkbox"/> Rheumatic fever      |  |
| <input type="checkbox"/> Hepatitis            |  |

20. Do any blood relatives have:

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

21. Describe serious accidents in the past.

- |  |
|--|
| <input type="checkbox"/> None  |
| <input type="checkbox"/> Occurred with head injury, loss of consciousness, or whiplash     |
| <input type="checkbox"/> Occurred without head injury, loss of consciousness, or whiplash. |
- Describe: \_\_\_\_\_

22. List all current medications and doses (include birth control pills, vitamins and herbs)

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23. Please list medication allergies:

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Novocaine  | <input type="checkbox"/> None known                       |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Keflex/Ceclor/Ceftin             |
| <input type="checkbox"/> Iodine     | <input type="checkbox"/> X-ray dyes                       |
| <input type="checkbox"/> Sulfa      | <input type="checkbox"/> Latex                            |
| <input type="checkbox"/> Codeine    | <input type="checkbox"/> Other (please<br>specify): _____ |

24. Please list operations:

- |   |   |
|---|---|
| <input type="checkbox"/> Tonsillectomy (age ____) | <input type="checkbox"/> Heart Surgery (age ____) |
| <input type="checkbox"/> Adenoidectomy (age ____) | <input type="checkbox"/> Other, please specify:   |
| <input type="checkbox"/> Appendectomy (age ____)  |   |

25. Have you had X-ray or radiation treatments to your head or neck (including treatments for acne or ear problems as a child, treatments for cancer, etc.)

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

26. Have you ever had training for your speaking voice?  Yes  No

- Acting voice lessons?  Yes  No  
 How long? \_\_\_\_\_  
 Speech therapy?  Yes  No  
 How long? \_\_\_\_\_

27. Do you play a musical instrument(s)?  Yes  No

If yes, which one(s) \_\_\_\_\_