

Richard W. Waguespack, MD

PHARYNX & LARYNX (Voice/Throat) QUESTIONNAIRE

Name: _____

Date: _____

Please print and complete this form to help us obtain your history.

Please circle response: How long have you had this problem? _____

When is your problem the worst? *Morning Afternoon Nighttime All day*

Yes No Do you know anything that may have caused your problem?

If Yes, what? _____

Yes No Do you have a sore throat?

Yes No Do you often have trouble swallowing?

Yes No Do you often **choke** or aspirate (have food or drink go into your windpipe)?

Yes No Have you had a swallowing **x-ray** (*barium swallow, esophagram, upper GI*) lately?

If Yes, when and where was it done? _____ What did it show? _____

Yes No Have you ever **smoked**? If Yes, how many packs/day? _____

For how many years? _____ If you have stopped, when? _____

Yes No Have you used any other form of tobacco? If Yes, please explain _____

Yes No Are you around any irritating **fumes** or substances? If Yes, what type? _____

Yes No Do you spend much time in a very hot or dry situation?

Yes No Do you have an active **nasal or sinus** condition? *If yes, also complete Nasal & Sinus form*

Yes No Do you have a frequent **cough** or a lung problem?

Yes No Have you had any **injury** to your throat? If Yes, please explain _____

Yes No Do you **strain** or overuse your voice? If Yes, please explain _____

Yes No Do you have any problem with **heartburn** or stomach acid/contents coming up into your throat (reflux)?

Please list all **medicines and treatments** given for your problem? None

Comments: