

VOICE DISORDERS CENTER OF BIRMINGHAM

VOICE PATIENT QUESTIONNAIRE

Please print and complete both pages to help us to obtain your history.

Name _____ Age _____ Sex _____

How long have you had your present voice problem? _____

Who noticed it? _____ It began? *Slowly or suddenly* _____

What do **you** think caused it? _____

Is it getting worse, *better or staying the same*? _____

Which symptoms do you have? (please check all that apply)

- Hoarseness (coarse or scratchy sound)
- Fatigue (voice tires or changes quality after use for a short period of time)
- Volume disturbance (trouble speaking or singing softly or loudly)
- Loss of (*low, mid or high*) range
- Prolonged warm-up time (over 1/2 hr to warm up voice)
- Breathiness
- Tickling or choking sensation while singing
- Pain with speaking or singing
- Other (*please describe*) _____

Occupation _____

What are your voice requirements? (*conversation only, singing, public speaking, teaching, etc.*) _____

Do you have to strain or overuse your voice? (*talking over loud background noise, cheerleading, choral direction, etc.*) _____

Do you have an important performance soon? Yes No If yes, what type and when? _____

Have you had voice training or speech therapy? Yes No If yes, please describe: _____

Who is your voice teacher, coach or therapist? _____

Do you use amplification? Yes No

Have any voice problems in the past required a visit to a physician? Yes No If yes, please describe problem(s) and treatment(s): _____

Please check all answers that apply to you:

- Voice worse in the morning
- Voice worse later in the day, *after use*
- Voice problem occurs unpredictably
- Voice problem constant most of the time
- Difficulty swallowing *Circle type(s): solids or liquids*
- Frequent choking or aspiration (food or drink going into the larynx or voicebox)
- Frequently clear your throat
- Bitter or acid taste, bad breath or hoarseness first thing in the morning
- Eat late at night
- Under particular stress at present? (personal or professional)
- Traveled recently? *Where?* _____ *When?* _____

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

Have you had a **cold, cough or sinus infection** recently? Yes No If yes, are symptoms still present?

What symptoms? _____

Do you have **reflux** (heartburn or stomach acid coming into your throat)? Yes No

Have you had any **x-rays** performed (*chest, sinuses, barium swallow or upper GI, etc.*) to evaluate your problem?

Yes No If yes, what type, when & where done: _____

Have you been evaluated by an **allergist**? Yes No If yes, give name, address, and results. _____

Have you ever smoked or used tobacco in any form? Yes No If yes, how many packs per day? _____

For how long? _____ If you no longer use tobacco, when did you quit? _____

How many glasses of **water** do you drink per day? _____

How many cups of **coffee, tea, cola** or other caffeine-containing drinks do you drink per day? _____

Are you exposed to any fumes, toxic agents or irritants? Yes No If yes, please explain: _____

List any **drugs** you use or have used (*marijuana, cocaine, etc.*): _____

Do you use over the counter medications? Yes No

If Yes, which ones? Decongestants Antihistamines Antacids Other _____

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

- | | |
|---|--|
| <input type="checkbox"/> Hypersensitivity to heat or cold | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Change in weight: Weight gained ___ lbs. | <input type="checkbox"/> Change in skin or hair |
| <input type="checkbox"/> Palpation (Fluttering) of the heart | <input type="checkbox"/> Emotional swings |
| <input type="checkbox"/> Double or blurred vision | <input type="checkbox"/> Numbness of the face or extremities |
| <input type="checkbox"/> Tingling around the mouth or face | <input type="checkbox"/> Weakness or paralysis of face |
| <input type="checkbox"/> Weakness or clumsiness in arms or legs | <input type="checkbox"/> Confusion or loss of consciousness |
| <input type="checkbox"/> Pain in the neck or shoulder | <input type="checkbox"/> Memory or personality change |
| <input type="checkbox"/> Shaking or tremors | |

What treatment have you had **in the past** for your voice problem? _____

What treatment are you on **now** for your voice problem? _____

Voice Disorders Center of Birmingham
Richard W. Waguespack, MD, FACS and Daniel E. Phillips, MA, CCC-SLP
St. Vincent's Professional Building I, Suite 201
2660 10th Avenue South, Birmingham, AL 35205
(205) 933-5068 Fax: (205) 933-9051