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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 Yes, please describe: ____

   Did it come on ☐**slowly** ☐**suddenly**?
   Is it getting ☐**worse** ☐**better** ☐**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 hour to warm up voice)
Breathiness
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?

   ☐ **Months** __________ ☐ **Years** ______________
   Teacher's name: ____
   Teacher's address:____
   Teacher's telephone number:_____________________________________

6. Please list previous teachers and number of years during which you studied with them:

Teacher's name: ____________________
Teacher's address: ____________________
Teacher's telephone number: ____________________
Number of years: __________

Teacher's name: ____________________
Teacher's address: ____________________
Teacher's telephone number: ____________________
Number of years: __________

7. Have you ever had training for your singing voice? **Yes** **No**

If Yes, list teachers and years of study:

Teacher's name: ____________________
Teacher's address: ____________________
Teacher's telephone number: ____________________
Number of years: __________

Teacher's name: ____________________
Teacher's address: ____________________
Teacher's telephone number: ____________________
Number of years: __________

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**
Date(s): ____________________

10. Do you do regularly exercises your voice? **Yes** **No**

If **Yes**, please describe them:

11. Do you play a musical instrument? **Yes** **No**

If Yes, please check all that apply.

Keyboard (piano, organ, harpsichord, other:)

Violin, viola	Wind with single reed
Cello	Wind with double reed
Bass	Flute, piccolo
Plucked strings (guitar, harp, other: ________________)	Percussion
Brass	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 the present (average hours per day)?
    - ☐ Rehearsal ______ hrs.
    - ☐ Performance _____ hrs.
    - ☐ Other _____ hrs.

7. Please check all that apply to you:

- Voice worse in the morning
- Voice worse later in the day, after it has been used.
- Sing performances or rehearsals in the morning
- Speak extensively (eg. teacher, clergy, attorney, telephone, work, etc)
- Cheerleader
- Speak extensively backstage or at post-performance parties.
- Choral conductor
- Frequently clear your 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 around extreme dryness
- Frequent exercise (weight lifting, aerobics, etc.)
- Frequently thirsty, dehydrated
- Hoarseness first thing in the morning
- Chest cough
- Eat late at night
- Used antacids
- Under particular stress at present (personal or professional)
- Frequent bad breath
- Live, work, or perform around smoke or fumes
- Used antacids
- Under particular stress at present (personal or professional)
- Frequent bad breath
- Live, work, or perform around smoke or fumes

8. Traveled recently: **Yes** **No**

   If Yes, When:________________________________ Where:_________________

9. Your Family doctor's name, address and telephone number:

   Family/Primary Doctor's name: ____

   Family/Primary Doctor's address:____

   Family/Primary Doctor's telephone number:______________________________________

10. Your laryngologist's name, address and telephone number:

Laryngologist's name: ____________________
Laryngologist's address: ____________________
Laryngologist's telephone number: ____________________

11. Recent cold.. **Yes** **No**

12. Current cold. **Yes** **No**

13. Do you have allergies? **Yes** **No**

14. Have you been evaluated by an allergist? **Yes** **No**
(If Yes, give name, address and telephone number of allergist:)

Allergist's name: ____________________
Allergist's address: ____________________
Allergist's telephone number: ____________________

What allergies do you have? Please check list.
*****(Medication allergies are covered elsewhere in this history form.)*****

None Cats
Dust Dog
Mold Foods
Trees Other: ____________________)

15. Smoking History **Yes** **No**

If Yes, how many packs of cigarettes do you smoke per day?
Smoke about ____________ packs per day for __________ years.

Quit Smoking. When? ______________

Smoked ______________ packs per day for _______ years.

16. Do you live or work in a smoky environment? **Yes** **No**

17. Do you consume alcohol? **Yes** **No**

If Yes, how often do you consume alcohol?
Rarely
A few times per week
Daily. If daily, or a few times per week, on average, how much do you consume?

(1, 2, 3, 4, 5, 6, 7, 8, 9, 10, more)

☐Glasses ☐ Bottles per **(☐day ☐week)** of **☐beer ☐wine ☐**

liquor

Did you used to drink more heavily? ☐ Yes ☐ No

18. How many cups of coffee, tea, cola or other caffeine-containing drinks do you drink per day?
(1 2 3 4 5 6 7 8 9 10 more)

19. List recreational drugs you use.

Marijuana
Cocaine
Amphetamines
Barbiturates
Heroin
Other: ____________
)

20. Have you noticed any of the follow?

Check all that apply.

Hypersensitivity to heat or cold
Excessive sweating
Change in weight: gain / lost ____ lbs
in ____weeks _____months
Change in your voice
Change in your skin or hair
Palpitation (fluttering) of your 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? _______
Have you gone through menopause? ☐ **Yes** ☐ **No**

21. Have you ever consulted a psychologist or psychiatrist? **Yes** **No**

Are your currently under treatment? ☐ **Yes** ☐ **No**

22. Have you injured your head or neck (whiplash, etc.)? **Yes** **No**

23. List any serious accidents related to this visit. **None**
Describe details of accident:

24. Are you involved in legal action involving problems with your voice?
☐ **Yes** ☐ **No**

25. Describe serious accidents not 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.
Please describe:

26. List names of spouse and children.

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

Hearing Loss
Ear Noises
Dizziness
Facial paralysis
nasal obstruction
nasal deformity
nose bleeds
mouth sores
excess facial skin
jaw joint problem (TMJ)
Ear pain
Facial pain
stiff neck
lump in neck
lump in face or head
trouble swallowing
trouble breathing
excess eye skin
eye problem
Other (please specify):

28. Do you have or have you ever had:

Diabetes
Hypoglycemia
Thyroid problems
Syphilis
Gonorrhea
Herpes
Cold sores (fever blisters)
High blood pressure
Severe low blood pressure
Intravenous antibiotics or diuretics
Heart attack
Angina
Irregular heartbeat
Other heart problems
Rheumatoid fever
Tuberculosis
Glaucoma
Multiple sclerosis
Seizures
Psychological therapy
Frequent bad headaches
Ulcers
Kidney disease
Urinary track problems
Arthritis or skeletal problems
Cleft palate
Asthma
Lung or breathing problems
Unexplained weight loss
Cancer of ____________________
Other tumor
Blood transfusions
Hepatitis
AIDS
HIV
Meningitis

29. Do any blood relatives have:
   Diabetes
   hypoglycemia
   cancer
   heart disease
   Other major medical problems such as those above. Please specify:

30. List all current medications and doses (including birth control pills and vitamins).

31. Medication Allergies

None	Novocaine
Penicillin	Iodine
Sulfa	Codeine
Tetracycline	Adhesive tape
Erythromycin	Aspirin
Keflex/Ceclor/Ceftin	X-ray dyes
	Other (please specify)

32. Operations. **Yes** **No**

   Tonsillectomy (age:)
   Appendectomy (age:)
   Adenoidectomy (age:)
   Heart surgery (age:)
   Other (please specify): ___________________________________

33. Toxic dugs or chemicals to which you have been exposed.
   Lead
   Mercury
   Streptomycin, Neomycin, Kanamycin
   Other (please specify):

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

   ☐ **Yes** ☐ **No**

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