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PATIENT HISTORY: SINGERS

NAME _____ AGE _____ SEX _____ RACE _____

HEIGHT _____ WEIGHT _____ DATE _____
VOICE CATEGORY: _____ soprano _____ mezzo soprano _____ alto
_____ tenor _____ baritone _____ bass

(If you are not currently having a voice problem, please skip to Question #3)
PLEASE CHECK OR CIRCLE CORRECT ANSWERS

1. How long have you had your present voice problem?
   Who noticed it?
   [self, family, voice teacher, critics, everyone, other _____]
   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** _____, **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 singing for a short period of time)
   _____ Volume disturbance (trouble singing) softly _____ loudly _____
   _____ Loss of range (high _____ low _____)
   _____ Change in classification (example: voice lowered from soprano to mezzo)
   _____ Prolonged warm-up time (over ½ hrs. to warm up voice)
   _____ Breathiness
   _____ Tickling or choking sensation while singing
   _____ Pain in throat while singing
   _____ Other (Please specify) _____
   _____
3. Do you have an important performance soon? **Yes** _____ **No** _____
   Date(s): _____
4. What is the current status of your singing career?
   Professional _____ Amateur _____
5. What are your long term career goals in singing?
   [ ] Premiere operatic career
   [ ] Premiere pop music career
   [ ] Active avocation
   [ ] Classical
   [ ] Pop
   [ ] Other [_____]
   [ ] Amateur performance (choral or solo)
   [ ] Amateur singing for own pleasure

6. Have you had voice training? **Yes** _____ **No** _____ At what age did you begin?
7. Have there been periods of months or years without lessons in that time? **Yes** _____ **No** _____

8. How long have you studied with your present teacher?
   Teacher's name:
   Teacher's address:
   Teacher's telephone number:
9. Please list previous teachers and years during which you studied with them:

10. Have you ever had training for your speaking voice? **Yes** _____ **No** _____
    Acting voice lessons? **Yes** _____ **No** _____
    How many years? _____
    Speech therapy? **Yes** _____ **No** _____
    How many months? _____
11. Do you have a job in addition to singing?
    Yes _____ **No** _____
    If yes, does it involve extensive voice use?
    Yes _____ **No** _____
    If yes, what is it? [actor, announcer (television/radio/sports arena), athletic instructor, attorney, clergy, politician, physician, sales person, stock broker, teacher, telephone operator or receptionist, waiter, waitress, secretary, other _____ **]**
12. In your performance work, in addition to singing, are you frequently required to speak? **Yes** ____ **No** ____
    dance? **Yes** ____ **No** ____
13. How many years did you sing actively before beginning voice lessons initially?
14. What types of music do you sing? **(Check all that apply.)**
    _____ Classical _____ Show
    _____ Night Club _____ Rock
    _____ Other: (Please specify) __ _____
15. Do you regularly sing in a sitting position (such as from behind a patio or drum set)? **Yes** ____ **No** ____
16. Do you sing outdoors or in large halls, or with orchestras? (Circle which one.) **Yes** ____ **No** ____
17. If you perform with electrical instruments or outdoors, do you use monitor speakers? **Yes** ____ **No** ____
    If yes, can you hear them? **Yes** ____ **No** ____
18. Do you play a musical instrument(s)? **Yes** _____ **No** ____
    If yes, please 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): _____

19. How often do you practice?
    Scales: **[daily, few times weekly, once a week, rarely, never]**
    If you practice scales, do you do them all at once or do you divide them up over the course of the day?
    [all at once, two or three sittings]
    On days when you do scales, how long do you practice them?
    [15, 30, 45, 60, 75, 90, 105, 120, more] minutes
    Songs: **[daily, few times weekly, once a week, rarely, never]**
    How many hours per day?
    [½, 1, 1½, 2, 2½, 3, more]
    Do you warm-up your voice before you sing? **Yes** _____ **No** _____
    Do you warm-up your voice when your finished singing? **Yes** _____ **No** _____
20. How much are you singing at present (total including practice time) (average hours per day)?
    Rehearsal:
    Performance:
21. 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 (e.g., teacher, clergy, attorney, telephone, work, etc.)
    _____ Cheerleader
    _____ Speak extensively backstage or at post-performance parities
    _____ Choral conductor
    _____ Frequently clear your throat
    _____ Frequent sore throat
    _____ Jaw joint problems
    _____ Bitter or acid taste, or bad breath first thing in the morning
    _____ Frequent "heartburn" or hiatal hernia
    _____ Frequent yelling or loud talking
    _____ Frequent whispering
    _____ Chronic fatigue
    _____ 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
    _____ 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: _____

    Eat/drink any of the following before singing?

    _____ Chocolate _____ Coffee
    _____ Alcohol _____ Milk or ice cream
    _____ Nuts _____ Spiced foods

    Other (Please specify):

    _____ Any specific vocal technical difficulties?
    [trouble singing soft, trouble singing loud, poor pitch control, support problems, problems at register transitions, other] Describe other:

_____ Any problems with your singing voice recently prior to the onset of the problem that brought you here?
[hoarseness, breathiness, fatigue, loss of range, voice breaks, pain singing, other] Describe others:

_____ Any voice problems in the past that required a visit to a physician? If yes, please describe problem(s) and treatment(s):
[laryngitis, nodules, polyps, hemorrhage, cancer, other] Describe other:

22. Your family doctor's name, address and telephone number:

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

24. Recent cold? **Yes _____ No _____**
25. Current cold? **Yes _____ No _____**

26. Have you been exposed to any of the following chemicals frequently (or recently) at home or at work:
(Check all that apply)

_____ Carbon monoxide	_____ Arsenic
_____ Mercury	_____ Aniline dyes
_____ Insecticides	_____ Industrial solvents
_____ Lead	_____ Industrial solvents (benzene, etc.)
_____ Stage smoke	

27. 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 history form.)
If yes, give name and address of allergist:

28. 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.
29. Do you work in a smokey environment? Yes _____ No _____
30. 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]**
Did you used to drink more heavily? **Yes _____ No _____**
31. How many cups of coffee, tea, cola or other caffeine-containing drinks do you drink per day?
32. List other recreational drugs you use **[marijuana, cocaine, amphetamines, barbiturates, heroin, other _____]**
33. 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 skin or hair
_____ Palpitation (fluttering) of the heart
_____ Emotional liability (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** _____
If yes, when?

34. Have you ever consulted a psychologist or psychiatrist? **Yes** _____ **No** _____
    Are you currently under treatment? **Yes** _____ **No** _____
35. Have you injured your head or neck (whiplash, etc.)? **Yes** _____ **No** _____
36. Describe any serious accidents related to this visit. None _____

37. Are you involved in legal action involving problems with your voice? **Yes** _____ **No** _____
38. List names of spouse and children:

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

PLEASE CHECK ALL THAT APPLY

_____ Hearing loss
_____ Ear noises
_____ Dizziness
_____ Facial paralysis
_____ Nasal obstruction
_____ Nasal deformity
_____ Mouth sores
_____ Jaw joint problem
_____ Eye problem
_____ Ear pain
_____ Facial pain
_____ Stiff neck
_____ Lump in the neck
_____ Lump in the face or head
_____ Trouble swallowing
_____ Excess eye skin
_____ Excess facial skin
_____ Other: (Please specify)

40. Do you have or have your ever had:

_____ Diabetes
_____ Hypoglycemia
_____ Thyroid problems
_____ Syphilis
_____ Gonorrhea
_____ Herpes
_____ Seizures
_____ Psych. therapy
_____ Frequent bad headaches
_____ Ulcers
_____ Kidney disease
_____ Urinary problems

_____ Cold sores (fever blisters)
_____ High blood pressure
_____ Severe low blood pressure
_____ Intravenous antibiotics or diuretics
_____ Heart attack
_____ Angina
_____ Irregular heartbeat
_____ Other heart problems
_____ Rheumatic fever
_____ Tuberculosis
_____ Glaucoma
_____ Multiple sclerosis
_____ Arthritis or skeletal problems
_____ Cleft palate
_____ Asthma
_____ Lung or breathing problems
_____ Unexplained weight loss
_____ Cancer of (_____)
_____ Other tumor (_____)
_____ Blood transfusions
_____ Hepatitis
_____ AIDS
_____ Meningitis
_____ Other illness, please specify:

41. Do any blood relatives have:

_____ Diabetes
_____ Hypoglycemia
_____ Cancer
_____ Heart disease
_____ Other major medical problems such as those above. Please specify:

42. 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:

43. List all current medications and doses (include birth control pills and vitamins).

44. Medication allergies

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

45. List operations

_____ Tonsillectomy (age____)
_____ Appendectomy (age_____)
_____ Other, please specify:
_____ Adenoidectomy (age_____)
_____ Heart surgery (age_____)

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

_____ Lead
_____ Mercury
_____ Streptomycin, Neomycin, Kanamycin
_____ Other, please specify:

47. 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** _____
48. Describe serious health problems of your spouse or children. _____ None.