

CENTRAL OHIO EAR, NOSE AND THROAT, INC.

Name: _____ Occupation: _____ Date: _____

Please indicate whether you have the following symptoms with a ✓

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Morning hoarseness | <input type="checkbox"/> Vocal fatigue | <input type="checkbox"/> Bitter/acid taste |
| <input type="checkbox"/> Can't sing | <input type="checkbox"/> Loss of pitch range | <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Breathy voice | <input type="checkbox"/> No voice at all | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hard to swallow |
| <input type="checkbox"/> Night Chokes | <input type="checkbox"/> Regurgitation | <input type="checkbox"/> Feels like something stuck in throat | |

Chronic cough → Wet and productive and/or Dry and hacking

1. VOICE difficulties Please describe your problem: _____

When did your voice problem begin? _____

How did it start? GRADUALLY SUDDENLY

Do you use your voice extensively at work? YES NO

Any pain associated with your voice problem? YES NO

What makes your voice better? _____ Worse? _____

Have you ever received voice therapy; when and where? _____

The following are statements that many people have used to describe their voices and the effects of their disordered voices on their lives. Circle the response that indicates how frequently you have the same experience.

0=Never 1=Almost Never 2=Sometimes 3=Almost Always 4=Always

- | | | | | | |
|--|---|---|---|---|---|
| 1) My voice makes it difficult for people to hear me | 0 | 1 | 2 | 3 | 4 |
| 2) My voice difficulties restrict personal and social life | 0 | 1 | 2 | 3 | 4 |
| 3) My voice problem affects my job performance | 0 | 1 | 2 | 3 | 4 |
| 4) My voice problem causes me to lose income | 0 | 1 | 2 | 3 | 4 |
| 5) The clarity of my voice is unpredictable | 0 | 1 | 2 | 3 | 4 |
| 6) My voice problem upsets me | 0 | 1 | 2 | 3 | 4 |
| 7) People ask, "What's wrong with your voice?" | 0 | 1 | 2 | 3 | 4 |

For singers: Where have you studied, and for how long? _____

Which voice part do you usually sing? SOPRANO MEZZO ALTO TENOR BARITONE BASS

What types of music do you usually sing? _____

2. SWALLOWING difficulties: (if not a problem then please skip to section 3.)

Do foods stick in your throat? YES NO Do you tend to choke when eating? YES NO

Are there certain food consistencies that give you greater swallowing difficulty than others (please circle)?

WATER THICK LIQUIDS PUDDING PUREES SOLIDS PILLS

Please turn over

3. BREATHING: (if not a problem then please skip to section 4.)

When did the problem begin? _____ How did it start? _____ GRADUALLY _____ SUDDENLY
Is your shortness of breath caused by _____ EXERTION, or does it occur _____ WITHOUT WARNING?
Is accompanying constriction localized in the _____ CHEST or _____ THROAT?
Generally, do have more difficulty getting breath _____ IN or _____ OUT?
What makes your breathing better? _____ worse? _____
Do you use inhalers? YES NO → How effective are they? VERY • SOMEWHAT • NOT AT ALL

4. DIET/LIFESTYLE:

Do you use tobacco? YES NO How many packs per day? _____ For how long? _____
Former smokers, when did you quit? _____ How much and how long did you smoke? _____
Do you regularly drink alcohol? YES NO What kind, and how much? _____
How many cups of coffee, tea, pop/soda, or other caffeinated beverages do you drink daily? _____
How many glasses of water do you drink per day? _____

Circle the following foods that you typically eat: SPICY FRIED FATTY DAIRY
CHOCOLATE PEPPERMINT/MINT ONIONS/GARLIC CITRUS FRUITS/JUICES

Do you typically eat within two hours of bedtime? YES NO
Any recent weight gain? YES NO If YES, when and how much? _____
How would you rate recent stress levels in your life? MILD • MODERATE • SEVERE

5. MEDICAL HISTORY:

Are you currently taking reflux medications? YES NO If so, for how long? _____
Please specify type(s): _____ dosage: _____ when taken: a.m. p.m.
If not now, have you taken reflux meds in the recent past? YES NO Please specify: _____

Are you allergic to topical anesthetics? YES NO Other allergies: _____

Prior medical conditions:

_____ Heartburn/reflux _____ Stomach ulcers _____ IBS _____ Sinusitis/rhinitis/PND
_____ Asthma _____ Emphysema _____ Heart disease/HTN _____ Depression/anxiety
_____ Fibromyalgia _____ Thyroid _____ Stomach ulcers _____ Hearing loss: __aided__unaided
_____ Cancer (please specify) _____ → _____ Radiation _____ Chemotherapy

Other conditions (e.g., arthritis, stroke, MS, PD) _____