

# Voice History Form

Developed by James P. Thomas, M.D., with permission

1. Referred by: \_\_\_\_\_ PCP ENT SP VT Letter? (circle one)

2. What is the main problem you are experiencing? (circle one)

Hoarseness Breathing Singing Swallowing Pain

3. What is your occupation? \_\_\_\_\_

4. When did your voice problem start? \_\_\_\_\_

5. Was the onset sudden? Y / N

6. Do you know what caused it? \_\_\_\_\_

7. Please summarize your voice problems briefly. \_\_\_\_\_

8. Please Mark all Abnormalities (Voice):

<input type="checkbox"/> hoarseness	<input type="checkbox"/> varies a lot	<input type="checkbox"/> drops to a whisper
<input type="checkbox"/> completely lost	<input type="checkbox"/> worse in the morning	<input type="checkbox"/> can't yell
<input type="checkbox"/> upper voice lost	<input type="checkbox"/> clear throat often	<input type="checkbox"/> can't be heard in noise
<input type="checkbox"/> effortful	<input type="checkbox"/> fades with use	<input type="checkbox"/> painful
<input type="checkbox"/> onset delay	<input type="checkbox"/> unsteady/wavers/strokes	<input type="checkbox"/> phone a problem
<input type="checkbox"/> poor endurance	<input type="checkbox"/> chokes off	<input type="checkbox"/> too low or high

9. Please Mark all Abnormalities (Swallowing):

<input type="checkbox"/> painful	<input type="checkbox"/> solids a problem	<input type="checkbox"/> antacid use	<input type="checkbox"/> frequently clearing throat
<input type="checkbox"/> old food comes up	<input type="checkbox"/> liquids a problem	<input type="checkbox"/> "heartburn" or hialal	<input type="checkbox"/> deeper voice in the morning
		<input type="checkbox"/> ulcer stress	<input type="checkbox"/> bad breath/taste in the morning

9. Reflux Symptoms:

10. Operations

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Lung	<input type="checkbox"/> Neck/Spine
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Voice Box	<input type="checkbox"/> Heart
<input type="checkbox"/> Nose/Sinus		<input type="checkbox"/> Other (please list): _____

11. Do you have problems in any of these areas?

<input type="checkbox"/> Heart	<input type="checkbox"/> Bladder/Kidney	<input type="checkbox"/> Diabetes/Thyroid	<input type="checkbox"/> Arm/Leg Weakness
<input type="checkbox"/> Stomach/Bowels	<input type="checkbox"/> Strokes	<input type="checkbox"/> Tremers/Unsteadiness	<input type="checkbox"/> Lungs (asthma, emphysema)

12. Are you a smoker?  Yes  No

If you're a previous smoker, when did you quit? \_\_\_\_\_

13. Fluid Consumption:

Water: \_\_\_\_\_ cups/cans/glasses per day  
Caffeine: \_\_\_\_\_ cups/cans/glasses per day (incl. coffee, tea, cola):  
Alcohol: \_\_\_\_\_ cups/cans/glasses per day

14. Do you have a family history of voice problems? Y / N

15. Do you have a family history of neurological problems? Y / N

16. Please list your current medications: \_\_\_\_\_

17. Medication Allergies:

<input type="checkbox"/> None	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Keflex, Ceflox, Cefitin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Codeine
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Novocaine	<input type="checkbox"/> X-Ray Dye
<input type="checkbox"/> Other (please list): _____			

