MILLER SPEECH AND HEARING CLINIC NEW PATIENT VOICE QUESTIONNAIRE

Name: ____________________________ Referring Doctor: ____________________________
Date of Birth: ____________________________ Referring Diagnosis: ____________________________
Address: ____________________________________________ Phone Number: ____________________________ (home)
__________________________________________ (business)
__________________________________________ (mobile)

History:
Occupation: ____________________________
When did your voice problem begin? ____________________________
Did your voice problem start suddenly or gradually? ____________________________
Describe your voice problem in your own words. ____________________________

__________________________________________
Do you feel it takes effort to speak? ____________________________ If yes, please explain when this occurs and how long effort to speak lasts. ____________________________

Has your voice returned to normal at any time since the problem began? ____________________________
If yes, please describe how long and how often normal voice is present. ____________________________

Does the problem worsen the more you talk? ____________________________
Does voice rest help your voice? ____________________________
Is it worse in the morning or in the afternoon/evening? ____________________________
Is your voice worse during certain seasons? ____________________________
Does anything help or hurt your voice? ____________________________
Are there any vocal activities you can no longer do secondary to this voice disorder? ____________________________
Can you be heard over ambient noise? ____________________________
Do others often ask you to repeat? ____________________________
What bothers you most about your voice problem? ____________________________
Do you participate in fewer social activities since your current difficulty began? _______ If yes, please explain. ____________________________
Has the problem interfered with any of your work activities (paid or volunteer)? _______ If yes, please explain. ____________________________
Compared to your recent voice problem, how does your voice sound today? (typical, somewhat better, much better, somewhat worse, much worse) ____________________________

Were there any events or conditions which you associate with the onset of your voice problem? (check all that apply and describe below)
NONE □ Upper respiratory infection (cold/flu) □
Increased voice use □ Swallowing difficulty □
Emotional stress □ Surgery □
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Vocal abuse (yelling/screaming) [ ] Other [ ] (Specify: __________________________)
Injury (trauma) [ ]
Describe:

Please check all the following symptoms that apply to you:

- hoarseness [ ]
- breathlessness [ ]
- gravelly voice quality [ ]
- harsh voice quality [ ]
- raspy voice quality [ ]
- strangling to speak [ ]
- voice too low or deep [ ]
- voice too high [ ]
- scratchy voice quality [ ]
- shaky voice [ ]
- unsteady voice [ ]
- voice breaks [ ]
- pitch breaks [ ]
- trouble speaking loudly [ ]
- trouble speaking softly [ ]
- whisper only (total loss of voice) [ ]
- noisy breathing [ ]
- nasality [ ]
- pain in throat [ ]
- heartburn [ ]
- indigestion [ ]
- bitter or metallic taste after waking [ ]
- sudden coughing after lying down [ ]
- chronic throat clearing [ ]
- chronic cough [ ]
- foreign body sensation in throat [ ]
- halitosis [ ]
- swallowing problems [ ]
- vocal fatigue [ ]
- worse voice when you wake [ ]
- increased or chronic post nasal drip [ ]
- tooth decay [ ]
- chronic bronchitis [ ]

How often do you experience reflux symptoms (daily, weekly, monthly)? __________________________
When reflux occurs, how do you treat it? ______________________________________________________

Do you have any pain and/or tension in your jaw, neck, or shoulders? ________ If yes, please indicate if this pain or tension is a sharp, stabbing pain, dull muscular ache, or a raw pain (like a sore throat). __________________________

Have you had the same or a similar voice problem in the past? ________ If yes, please explain. ____________________________________________________________

Have you ever had therapy or surgery for this or any other voice related condition? __________
If yes, please list dates, location, therapists, and results of therapy. ____________________________________________________________

Have you had any choking or swallowing problems? ________ If yes, please explain how often, when, and with what food or drink consistencies. ____________________________________________________________

Do you have pain when swallowing? __________________________
Have you had any recent surgeries? ________ If yes, please explain. __________________________

Have you had any recent neck injuries? ________ If yes, please explain. __________________________

Have you ever worked around any toxic fumes (gas, paint, chemicals)? ________ If yes.
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please explain.
List current neurological problems (diagnoses and dates).

Do you have a known (diagnosed) hearing loss? If yes, do you or have you ever worn hearing aids?

Social History:
Are you single? married? widowed?
Do you live alone? If no, with whom?

Do you have children? If yes, please list how many and if you have grandchildren.

Please list your education level.

General Medical Health:
Arthritis □
Asthma (adult/childhood onset) □
Bronchitis □
Blood Sugar (high/low) □
Diabetes (adult/childhood onset) □
Headaches □
Heart Disease □
Other: ____________________________

High Blood Pressure □
Kidney/Bladder Disease □
Liver Disease □
Lung Disease □
Joint/Bone Disease □
Tuberculosis □
Cancer □
Thyroid disease □
Neurologic Disorders □
Depression □
Bleeding Problems □
Stroke □
GI Disorders (hermia, ulcers, colitis, etc.) □
Sinus Disease □
Endocrine Disorder □

Do you have allergies to foods? drugs? environments?

For females only:
Are you pregnant?
Have you gone through menopause?
Do you have regular menstrual cycles?
If yes, please date of most recent period.
Does your voice change during your menstrual cycle? If yes, please describe.

Vocal Use:
*Please answer the following questions using this scale: 1 = less than average, 2 = average, 3 = more than average.
Do you scream (not necessarily in anger, for example, at a sporting event or while working in a
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Do you raise your voice (e.g. parenting, calling from room to room, etc.)?  
Do you talk for extended periods of time without a break (e.g. teacher, singer)?  
Are you a talker?  
Do you clear your throat?  
Do you cough?  
Do you sing? If yes, please explain.  

How often are you on the phone?  
Do you do impersonations, character voices or unusual sound effects? If yes, please explain.  
Please list any hobbies or activities you enjoy.  

Vocal Hygiene:  
What is your weight?  
How many glasses of water do you drink a day (1 glass = 1 cup or 8 oz.)?  
How many caffeinated beverages do you drink a day? coffee , tea , soda , chocolate .  
Do you drink alcohol? If yes, please indicate what kind and how often.  
Do you use any tobacco products (cigarettes, pipe, cigar, snuff, chew, or dip) or have you ever used tobacco products? If yes, please indicate what kind, how often, and how long.  

If you quit smoking, please list when.  
Are you around someone who smokes?  
How many glasses of milk do you drink per day?  
Are you currently taking antihistamines? If yes, list type and dosage.  

Are you in particularly dry environments? If yes, please explain.  

Do you fly frequently?  
Do you take anything with menthol in it? If yes, please list item and how often taken.  

Are you around stage smoke? If yes, please indicate whether oil or water based.  
Do you take Vitamin C? If yes, please list dosage and frequency of use.  

Do you use recreational drugs, specifically marijuana? If yes, please list frequency.  

Do you take weight control pills? If yes, please list dosage and frequency.
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Please list current medications (over the counter and prescription).

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NONE

What is your goal regarding your problem or condition?

Do you have a follow-up appointment scheduled with your referring physician? If so, please list date and time.

Would you like this report sent to anyone other than the referring physician? If so, please list name and contact information.

__________________________
Patient Signature

__________________________
Date