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

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 ☐	High Blood Pressure ☐	Depression ☐
Asthma (adult/childhood onset) ☐	Kidney/Bladder Disease ☐	Bleeding Problems ☐
Bronchitis ☐	Liver Disease ☐	Stroke ☐
Blood Sugar (high/low) ☐	Lung Disease ☐	GI Disorders (hernia, ulcers, colitis, etc.) ☐
Diabetes (adult/childhood onset) ☐	Joint/Bone Disease ☐	Sinus Disease ☐
Headaches ☐	Tuberculosis ☐	Endocrine Disorder ☐
Heart Disease ☐	Cancer ☐	
	Thyroid disease ☐	
	Neurologic Disorders ☐	

Other:_____
_____
_____

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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noisy environment)?_____
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).

_____**NONE**

Medication		**Condition**
1. _____	for	_____
2. _____	for	_____
3. _____	for	_____
4. _____	for	_____
5. _____	for	_____
6. _____	for	_____
7. _____	for	_____
8. _____	for	_____
9. _____	for	_____
10. _____	for	_____

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