PATA REHABILITATION SPECIALISTS

Voice Case History

Name: ____________________

Address: ____________________

Telephone: (H)____________________ **(C)**____________________

DOB: ____________________ **Profession:** ____________________

Referral: ____________________

Referral Address: ____________________

Would you like a report sent to your referral source? ☐ **YES** ☐ **NO**

Family Physician: ____________________

Family Physician Address: ____________________

Would you like a report sent to your physician? ☐ **YES** ☐ **NO**

Would you like a report sent to any other source? ☐ **YES** ☐ **NO**

Name/Relationship: ____________________

Address: ____________________

MEDICAL HISTORY

Current status of health: ☐ Very good ☐ Fair ☐ Poor

Indicate all medical conditions you have currently or have had in the past:

☐ Asthma/allergies	☐ Heart murmur/condition	☐ Reflux
☐ Arthritis	☐ Hepatitis	☐ Stomach problems/ulcers
☐ Cancer	☐ High blood pressure	☐ Stroke
☐ Diabetes	☐ HIV/AIDS	☐ Thyroid disorder
☐ Environmental allergies	☐ Lung disease	☐ Other: ____________
☐ Heart attack	☐ Psychiatric treatment	☐ No significant history

Explain any existing medical conditions, allergies, or other diagnoses:

____

____

____

VOICE HISTORY

Describe the problems you are having with your voice:

____

____

When did you first notice a change in your voice? ________________________________

Is there an event you can associate with the onset of your voice problem? ☐ **YES** ☐ **NO**

If yes, explain. ____

Does your voice problem vary throughout the day: ☐ **YES** ☐ **NO**

If yes, explain. ____

Since the onset of your voice problem, it has:

☐ **Gotten better** ☐ **Stayed the same** ☐ **Gotten worse**

Have you had any difficulty with your voice in the past? ☐ **YES** ☐ **NO**

If yes, explain. ____

List any previous surgeries with their approximate date:

____

____

____

Did you start taking any new medications around the onset of your voice issue? ☐ **YES** ☐ **NO**

If yes, explain. ____

List all current medications and/or herbal supplements:

____

____

____

Are you exposed to environmental toxins regularly at work? ☐ **YES** ☐ **NO**

If yes, explain. ____

Do you use tobacco products? ☐ **YES** ☐ **NO**

If yes, what kind? ____________________ **For how many years?** ____________

Do you drink alcohol? ☐ **YES** ☐ **NO** **If yes, how often?** _______________

Do you drink coffee? ☐ **YES** ☐ **NO** **If yes, how much daily?** __________

Please check all the following statements that are true:

- ❒ I have trouble swallowing liquids.
- ❒ I have trouble swallowing solids.
- ❒ I frequently have coughing spells while eating.
- ❒ I lose fluid through the nose when vomiting.
- ❒ I frequently clear my throat.
- ❒ I have frequent tension headaches.
- ❒ I have frequent pain in my neck.
- ❒ I experience heartburn.
- ❒ I frequently belch and/or have an acidic taste in my mouth.
- ❒ I avoid certain foods because they upset my stomach/I have an allergy/intolerance.

  If yes, which foods: ____

On a scale from 1 (best voice) to 10 (worst voice), how would you rate your voice? _______

On a scale from 1 (no effort) to 10 (high effort), how much effort does it take to produce your voice? _______

What would you like to gain from today's evaluation? Circle all that apply.

a. A better understanding of my voice issue
b. A way to manage my voice issue
c. Physical relief
d. Peace of mind
e. For my voice issue to go away
f. Other: ____

____________________________________ ______________________

Patient Signature **Date**