



Patient Identification

Complaint (Please state the main concern in your own words): \_\_\_\_\_

When did you first notice a problem with your voice? \_\_\_\_\_

Please describe the course of the problem, the treatment you have had, where, and who treated you.

Please describe any feelings you have in your throat (such as tickle, lump, pain, difficulty swallowing, etc.)

Does your voice get better, worse, or stay the same? \_\_\_\_\_

When is it better? \_\_\_\_\_

When is it worse? \_\_\_\_\_

Do you have any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Neurological Problems      |
| <input type="checkbox"/> Breathing or Lung Problems | <input type="checkbox"/> Endocrine/Hormone Problems |

Have you had any of the following?

- |   |       |       |
|---|-------|-------|
| <input type="checkbox"/> Surgery on your larynx?          | When? | _____ |
| <input type="checkbox"/> Heart Surgery?                   | When? | _____ |
| <input type="checkbox"/> Chest Surgery?                   | When? | _____ |
| <input type="checkbox"/> Thyroid Surgery?                 | When? | _____ |
| <input type="checkbox"/> Stroke?                          | When? | _____ |
| <input type="checkbox"/> Injury to the Neck?              | When? | _____ |
| <input type="checkbox"/> Chemical or Inhalation Exposure? | When? | _____ |

Do you:

- Smoke? (Tobacco or other substance)  
How Much? \_\_\_\_\_
- Drink? (Beer, wine, or other alcoholic substance)  
How Much? \_\_\_\_\_
- Take any medication regularly? (Include aspirin)  
What? \_\_\_\_\_
- Talk above noise? What noise? \_\_\_\_\_  
How Often? \_\_\_\_\_
- Talk loud, scream, yell? How often? \_\_\_\_\_
- Sing:  Choir  Solo  with Musical Group

Are you employed?  Yes  No

What kind of work do you do? \_\_\_\_\_

Is talking required for your \_\_\_\_\_

Please add any other information which you think may be important: