

# VOICE INFORMATION FORM

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Tentative Diagnosis \_\_\_\_\_

Address: Permanent \_\_\_\_\_ Birthdate: \_\_\_\_\_

Temporary \_\_\_\_\_ Marital Status \_\_\_\_\_

Profession: Full Time \_\_\_\_\_

Telephone number \_\_\_\_\_ Part Time \_\_\_\_\_

Date of initial referral \_\_\_\_\_

Reason for Referral \_\_\_\_\_

Client's or informant's explanation of voice problem \_\_\_\_\_

Referral source: Physician's name \_\_\_\_\_

Non-physician's name \_\_\_\_\_

Address \_\_\_\_\_

Previous history of voice or speech problem \_\_\_\_\_

**I. Check and explain any of the following if pertinent:** Yes/No When or How Long

1. Post-nasal drip \_\_\_\_\_

2. Persistent cough or sneeze \_\_\_\_\_

3. Frequent "colds" or "flu" \_\_\_\_\_

4. Colds that "hang on" for more than two weeks \_\_\_\_\_

5. Sinus infections \_\_\_\_\_

6. Sinus headaches \_\_\_\_\_

7. Allergy (hay fever, hives, throat swelling, itchiness) \_\_\_\_\_

8. Family history of allergy \_\_\_\_\_

9. Asthma \_\_\_\_\_

10. History of infected tonsils/adenoids \_\_\_\_\_

11. Many dental caries or gum infections \_\_\_\_\_

12. Middle ear infections \_\_\_\_\_

13. Ruptured eardrum (running ear) \_\_\_\_\_

14. Emphysema \_\_\_\_\_

15. Recurrent "strep throat" \_\_\_\_\_

16. Mononucleosis \_\_\_\_\_

17. Laryngeal pain \_\_\_\_\_

18. Bitter or sour taste in mouth at night or upon arising after sleep \_\_\_\_\_

19. Surgery For: \_\_\_\_\_ When: \_\_\_\_\_

a. Thyroid \_\_\_\_\_

b. Tonsils \_\_\_\_\_

c. Adenoids \_\_\_\_\_

d. Ear infections \_\_\_\_\_

e. Cancer \_\_\_\_\_

f. Vocal polyps or nodules \_\_\_\_\_

g. Laryngeal web \_\_\_\_\_

h. Other (explain) \_\_\_\_\_

20. Orthodontia \_\_\_\_\_

21. Musical instruments played \_\_\_\_\_

**II. Life Style:**

1. Occupation: \_\_\_\_\_
2. Do you use your voice a great deal in your work? \_\_\_\_\_
3. Work environment
  - a. Does the job require much driving? \_\_\_\_\_
  - b. One work location or more than one? \_\_\_\_\_
  - c. Do you work alone or with other people? \_\_\_\_\_
  - d. Do you spend much time on the telephone? \_\_\_\_\_
  - e. How do you hold the telephone? \_\_\_\_\_  
    With your hand? \_\_\_\_\_  
    With a prop? \_\_\_\_\_  
    Held in place by shoulder and chin? \_\_\_\_\_
  - f. Do you like your job? \_\_\_\_\_
  - g. Is your work space: \_\_\_\_\_  
    Too noisy? \_\_\_\_\_  
    Too quiet? \_\_\_\_\_  
    Too dry? \_\_\_\_\_  
    Too moist? \_\_\_\_\_  
    Too warm? \_\_\_\_\_  
    Too cool? \_\_\_\_\_  
    Too dusty? \_\_\_\_\_  
    Too small? \_\_\_\_\_  
    Other \_\_\_\_\_
- Is your home environment: \_\_\_\_\_  
    Noisy? \_\_\_\_\_  
    Quiet? \_\_\_\_\_  
    Too small? \_\_\_\_\_  
    Too dry? \_\_\_\_\_  
    Too moist? \_\_\_\_\_  
    Too dusty? \_\_\_\_\_  
    Too drafty? \_\_\_\_\_  
    Heated by hot air? \_\_\_\_\_  
    Heated by electric space heaters? \_\_\_\_\_  
    Other \_\_\_\_\_
4. Which language besides English do you speak? \_\_\_\_\_
  - a. at home? \_\_\_\_\_
  - b. at work? \_\_\_\_\_
5. Are you, or have you been, hard of hearing or deaf? \_\_\_\_\_
6. Is anyone in your home or working with you hard of hearing or deaf? \_\_\_\_\_
7. What are your hobbies or preferred activities? \_\_\_\_\_
8. Do you attend sports events as a "fan"? \_\_\_\_\_
9. Were you or are you a cheer leader? \_\_\_\_\_
10. Do you smoke? \_\_\_\_\_

	Yes	No	How much daily?
a. cigarettes? _____	_____	_____	_____
b. pipes? _____	_____	_____	_____
c. cigars? _____	_____	_____	_____
d. other _____	_____	_____	_____
11. Do you dip or chew snuff? \_\_\_\_\_
12. Do you drink more than one average serving daily of-
  - a. beer? \_\_\_\_\_
  - b. wine? \_\_\_\_\_
  - c. cordials? \_\_\_\_\_
  - d. whiskey or other drinks of 80 proof and over? \_\_\_\_\_
13. What do you think caused your vocal problem? \_\_\_\_\_
14. Are there specific times of day, days of the week or situations where your voice is especially bad? \_\_\_\_\_