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Voice Clinic Pre Assessment Questionnaire

Clinic Date.................

Name:.. Date of birth:................................ Male/Female

What is your profession/occupation?...

Check any of the following symptoms that apply to you:

- □ Hoarseness
- □ Throat pain
- □ Loss of volume
- □ Breathy Voice
- □ Vocal fatigue
- □ Chronic cough
- □ Excessive phlegm
- □ Frequent throat clearing
- □ Problems breathing
- □ Heartburn
- □ Postnasal drip
- □ Bitter/acid taste in mouth
- □ Reduced singing range
- □ Change in singing range/quality
- □ Choking/coughing on liquids
- □ Choking/coughing on solids
- □ Food sticking in the throat
- □ Difficulty swallowing pills
- □ Painful swallowing
- □ Feeling of something caught in the throat/tickling sensation

When did your symptoms begin? .... days / weeks / months / years ago

Did they begin gradually or suddenly? □ Gradual onset □ sudden onset

Did anything happen/change around the time your symptoms began (surgery, illness, change in medication, diet, stress, etc.)? Explain:

Medical History

- □ Neurological Disease:
  - □ Stroke / CVA / TIA
  - □ Myasthenia Gravis
  - □ Parkinson's Disease
  - □ Multiple Sclerosis
  - □ Other
- □ Allergies
- □ Chronic Sinusitis
- □ Respiratory Disorders
  - □ Asthma
  - □ COPD/Emphysema
  - □ Bronchitis
  - □ Pneumonia
- □ Heart Disease
- □ High blood pressure
- □ Arthritis
- □ Gastro-intestinal Disease
  - □ Reflux disease
  - □ Hiatal hernia
  - □ Other:
- □ Surgeries to the head/neck region
- □ Injuries to the head/neck region
- □ Seizure Disorder
- □ Diabetes
- □ Kidney Disease
- □ Ulcers
- □ Cancer:
- □ Thyroid disease
- □ Other:

Social history

Do you currently use any of the following tobacco products? □ Yes □ No □ Previously

□ Cigarette □ cigar □ pipe □ chewing tobacco How much: _______

Do you drink alcohol now? □ Yes □ No

How many alcoholic drinks per day? ____

How many glasses of caffeinated beverages (coffee, tea, soda) do you drink each day? ______

How many glasses of water do you drink each day? ______

Employment: ☐ Full Time ☐ Part time ☐ Retired

Your work environment is:	☐ stressful	☐ noisy	☐ quiet	☐ large	☐ dusty
	☐ dry	☐ moist	☐ small	☐ warm	☐ cold
Your job requires:	☐ a lot of talking	☐ a lot of phone usage	☐ working with chemicals	☐ talking above noisy equipment	☐ Singing

VOICE HISTORY

Voice activity (at work & home): ☐ High user ☐ Average User ☐ Low user

I would rate my degree of talkativeness as the following: (circle response)

1	2	3	4	5	6	7
Quiet Listener			Average talker			Extremely Talkative

Circle one of the following statements that best describes your voice:

'Comes and goes' **'Always the same'** **'Suddenly lost then found'** **'Gradually getting worse'**

Circle the following voice qualities that best describe your voice:

Hoarse **Rough** **Weak** **Breathy** **Strained**

High Pitched **Low Pitched** **Fatigued** **Husky**

Is there anything that helps your voice quality improve? ………………………………………………….

Is there anything that makes it worse?…………………………………………………………………………

When do you see your voice difficulty resolving? ……………………………………………………………..

Have you noticed any of the following symptoms in your throat? Please circle

Dryness **Soreness** **Sharp Pain** **Throat Clearing Strain**

TensionExcess Mucus **Swallowing Difficulties** **Any other**……………….

Have you had an assessment by ENT for your voice before Yes/No
If Yes, what were the findings and when was the assessment?

………

Have you had Speech and Language Therapy before Yes/No
If Yes, what was this for and was this helpful?

………

Thank you for completing the questionnaire

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