**Texas Voice Performance Institute**

[***www.texasvoice.org***](http://www.texasvoice.org/)

**New Patient Questionnaire**

Rev. 2011-04-28 **Page 1 of 5**

**DO NOT SCAN.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | | MRN | DOB | Date |
| Telephone |  |  |  |  |
| H | W | M |  |  |
| Pharmacy |  |  |  |  |
| Name | Telephone | |  |  |
| How did you hear about us?   * Sent by another physician (If so, please give name below.) * Sent by a friend * Internet search * UT reputation * Other *(Specify)* | | | | |
| Physician #1 ( sent by this physician) | | | | |
| Name | Fax |  | Telephone |  |
| Address | City, State |  | Zip |  |
| Physician #2 ( sent by this physician) | | | | |
| Name | Fax |  | Telephone |  |
| Address | City, State |  | Zip |  |

**Important Note on Medical Records**

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the neck and throat may be important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

**START HERE:**

**What problem gives you the most trouble?**

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**VOICE HANDICAP INDEX (VHI-10)**

Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Please fill in the bubble of the response that indicates how frequently you have the same experience.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Never** | **Almost Never** | **Sometimes** | **Almost Always** | **Always** |
| F1 | My voice makes it difficult for people to hear me. |  |  |  |  |  |
| P2 | I run out of air when I talk. |  |  |  |  |  |
| F3 | People have difficulty understanding me in a noisy room. |  |  |  |  |  |
| P4 | The sound of my voice varies throughout the day. |  |  |  |  |  |
| F5 | My family has difficulty hearing me when I call them throughout the home. |  |  |  |  |  |
| P6 | I use the phone less often than I would like to. |  |  |  |  |  |
| E7 | I’m tense when talking to others because of my voice. |  |  |  |  |  |
| F8 | I tend to avoid groups of people because of my voice. |  |  |  |  |  |
| E9 | People seem irritated with my voice. |  |  |  |  |  |
| P10 | People ask, “What’s wrong with your voice?” |  |  |  |  |  |
|  |  | 0 | 1 | 2 | 3 | 4 |

VHI-10: /40

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**Reflux Symptom Index**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Within the last month, how did the following problems affect you?** | **No problem** |  | | | | **Severe Problem** |
| Hoarseness or a problem with your voice |  |  |  |  |  |  |
| Clearing your throat |  |  |  |  |  |  |
| Excess throat mucus or postnasal drip |  |  |  |  |  |  |
| Difficulty swallowing food, liquids, or pills |  |  |  |  |  |  |
| Coughing after you ate or after lying down |  |  |  |  |  |  |
| Breathing difficulties or choking episodes |  |  |  |  |  |  |
| Troublesome or annoying cough |  |  |  |  |  |  |
| Sensations of something sticking in your throat or a lump in your throat |  |  |  |  |  |  |
| Heartburn, chest pain, indigestion, or stomach acid coming up |  |  |  |  |  |  |
|  | 0 | 1 | 2 | 3 | 4 | 5 |

RSI: /45

**Review of Systems**

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*The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Treated by another physician** |  |  | **Yes** | **No** | **Treated by another physician** |
| **General** |  |  |  | **Gastro-intestinal** | | | |
| Nausea |  |  |  | Heartburn |  |  |  |
| Weight gain |  |  |  | Belly pain |  |  |  |
| Weight loss |  |  |  | Diarrhea |  |  |  |
| Fevers/chills |  |  |  | Constipation |  |  |  |
| **Ears, Nose & Throat** | | | | Vomiting |  |  |  |
| Hoarseness |  |  |  | **Skin** | | | |
| Hearing loss |  |  |  | Rashes |  |  |  |
| Draining ear |  |  |  | Ulcers |  |  |  |
| Vertigo |  |  |  | **Musculo-skeletal** | | | |
| Loud snoring |  |  |  | Muscle pain |  |  |  |
| Daytime sleepiness |  |  |  | Muscle weakness |  |  |  |
| Mouth sores |  |  |  | **Endocrine** | | | |
| Tooth problems |  |  |  | Cold intolerance |  |  |  |
| Painful/difficult swallowing |  |  |  | Heat intolerance |  |  |  |
| Ringing in the ears |  |  |  | Excessive thirst |  |  |  |
| **Eyes** | | | | **Hematologic** | | | |
| Double vision |  |  |  | Anemia |  |  |  |
| Blurry vision |  |  |  | Bleeding |  |  |  |
| **Cardiac** | | | | Bruising |  |  |  |
| Chest pain |  |  |  | **Neurological** | | | |
| Short of breath |  |  |  | Seizures |  |  |  |
| **Respiratory** | | | | **Psychiatric** | | | |
| Wheezing |  |  |  | Depression |  |  |  |
| Cough |  |  |  | Anxiety |  |  |  |

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**DO NOT SCAN.**

**Past History**

Do you have any of the following medical problems? (Please mark the circle to indicate “Yes”.)

 Arthritis

 Asthma

 Bleeding disorder

 Cataracts

 Chronic fatigue syndrome

 Depression

 Diabetes

 Fibromyalgia

 Gastritis

 Glaucoma

 Hepatitis

 High blood pressure

 Heart disease

 Immunodeficiency

 Kidney disease

 Meningitis

 Migraine headache

 Mitral valve prolapse

 Peptic ulcer disease

 Seizures

 Thyroid disease

 Tuberculosis (TB)

Please list any surgery you have had:

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

 Yes

 No

*(If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?

 No

 Yes

*Medication Reaction*

**Family History**

Do any of your family members have any of the following conditions?

|  |  |
| --- | --- |
|  Allergy   Asthma   Bleeding disorder |  Heart disease   Immunodeficiency   Cancer |

**Social History**

|  |  |
| --- | --- |
| What is your occupation? |  |
| Have you had any recent change in your home or work environment?   Yes   No | Details |
| Have you ever smoked?   Yes-currently   Yes- but I quit:   No | Details |
| Do you drink alcoholic beverages?   Yes   No | Details |
| Have you ever used any illicit substances?   Yes   No*.* | Details |