NORTHWEST CLINIC FOR VOICE AND SWALLOWING NEW PATIENT INTAKE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Save File

Patient Name: _____

Primary Care Provider: _____ Address: _____

Other Provider: _____ Address: _____

Provider Specialty: _____

Preferred Pharmacy: _____

Please ***briefly*** describe the nature of your current problem:

_____

_____

_____

How long has this troubled you? _____ ☐ Days ☐ Weeks ☐ Months

VOCAL HISTORY:

If not already described, have you noted problems in these areas?

☐ Hoarseness ☐ Swallowing difficulty/ discomfort ☐ Breathing difficulty ☐ Cough

If you have problems with your voice, please indicate which of the following troubles you have noted (Check all that apply)

☐ Poor vocal quality	☐ Inability to yell	☐ Loss of high range
☐ Fluctuating voice	☐ Trouble voicing in noise	☐ Loss of low range
☐ Weak voice	☐ Whisper voice	☐ Lowered pitch
☐ Effortful voicing	☐ Trouble voicing on phone	☐ Elevated pitch
☐ Pain with talking	☐ Pitch breaks	☐ Discomfort with voicing

Please describe other voice problems: _____

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Please respond to the following questions regarding hoarseness and its impact on your daily activities. (*If hoarseness is not a problem for you, please indicate this fact on the table*.)

Question	Never	Almost Never	Sometimes	Almost Always	Always
F1. My voice makes it difficult for people to hear me.	☐	☐	☐	☐	☐
F2. People have difficulty understanding me in a noisy room.	☐	☐	☐	☐	☐
F3. My family has difficulty hearing me when I call them throughout the house.	☐	☐	☐	☐	☐
F4. I use the phone less often than I would like.	☐	☐	☐	☐	☐
F5. I tend to avoid groups of people because of my voice.	☐	☐	☐	☐	☐
F6. I speak with friends, neighbors, or relatives less often because of my voice.	☐	☐	☐	☐	☐
F7. People ask me to repeat myself when speaking face- to-face.	☐	☐	☐	☐	☐
F8. My voice difficulties restrict my personal and social life.	☐	☐	☐	☐	☐
F9. I feel left out of conversation because of my voice.	☐	☐	☐	☐	☐
F10. My voice problem causes me to lose income.	☐	☐	☐	☐	☐
P11. I run out of air when I talk.	☐	☐	☐	☐	☐
P12.The sound of my voice varies throughout the day.	☐	☐	☐	☐	☐
P13. People ask “what’s wrong with your voice?”	☐	☐	☐	☐	☐
P14. My voice sounds creaky and dry.	☐	☐	☐	☐	☐
P15. I feel as though I have to strain to produce voice.	☐	☐	☐	☐	☐
P16. The clarity of my voice is unpredictable.	☐	☐	☐	☐	☐
P17. I try to change my voice to sound different.	☐	☐	☐	☐	☐
P18. I use a great deal of effort to speak.	☐	☐	☐	☐	☐
P19. My voice is worse in the evening.	☐	☐	☐	☐	☐
P20. My voice “gives out” on me in the middle of speaking.	☐	☐	☐	☐	☐
E21. I am tense when talking with others because of my voice.	☐	☐	☐	☐	☐
E22. People seem irritated with my voice.	☐	☐	☐	☐	☐
E23. I find other people don’t understand my voice problem.	☐	☐	☐	☐	☐
E24. My voice problem upsets me.	☐	☐	☐	☐	☐
E25. I am less out-going because of my voice problem.	☐	☐	☐	☐	☐
E26. My voice makes me feel handicapped.	☐	☐	☐	☐	☐
E27. I feel annoyed when people ask me to repeat myself.	☐	☐	☐	☐	☐
E28. I feel embarrassed when people ask me to repeat myself.	☐	☐	☐	☐	☐
E29. My voice makes me feel incompetent.	☐	☐	☐	☐	☐
E30. I am ashamed of my voice problem.	☐	☐	☐	☐	☐

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Please check the word that describes how severe your primary problem is ***today***

☐ Not a problem ☐ Mild ☐ Moderate ☐ Severe

To the best of your ability, please describe the progression of your problem including the treatment efforts that have or have not been successful. (Please include any medical treatment as well as any therapies.)

_____

_____

_____

_____

Please **list any studies** you have had for this or any other recent evaluation of the head or neck. *Studies of interest include: CT or MRI scans of the head, neck or chest, swallowing evaluations, laryngeal or stroboscopic examinations, swallowing studies, esophageal or upper GI endoscopies, etc . . .* If at all possible, *please obtain copies of the reports or the studies themselves and bring these with you to your visit. This will allow for the most efficient and comprehensive evaluation possible and prevent duplication of studies*

Study: _____ Month/Year: _____ Location: _____

Study: _____ Month/Year: _____ Location: _____

Study: _____ Month/Year: _____ Location: _____

☐ I have more studies listed on the last page of this form.

VOCAL DEMANDS *(check all that apply):*

☐ Conversational speech ☐ Are you talkative? ☐ Heavy telephone use

☐ Wireless telephone use ☐ Frequent presentations ☐ Coaching

☐ Teaching ☐ Recreational/church singing ☐ Professional singing

☐ Acting

If you are a singer, Please describe your range: _____

Were you formally trained? Please describe: _____

Please describe your singing style: _____

Please describe the venues or situations in which you sing most commonly: _____

_____

Do you warm-up before singing? If so, please describe your typical warm-up: _____

_____

Are you monitored when you sing? If so, please describe type (floor, in-ear, etc ...):_____

_____

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MEDICAL HISTORY:

Please list all **current medical problems**. *Please include all conditions for which you take prescription or over-the counter medication.*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

☐ I have more medical problems listed on the last page of this form.

Please list all **surgeries you have had on the head or neck**. *Please include all childhood procedures, including tonsillectomy, adenoidectomy, etc.*

_____ Approximate Date: _____
_____ Approximate Date: _____
_____ Approximate Date: _____

☐ I have more head or neck surgeries listed on the last page of this form

Please list **all other surgeries, procedures or hospitalizations** you have had. *Please be sure to include any procedures or hospitalizations you have had recently that required general anesthesia.*

_____ Approximate Date: _____
_____ Approximate Date: _____
_____ Approximate Date: _____
_____ Approximate Date: _____

☐ I have more surgeries, procedures or hospitalizations listed on the last page of this form

Medications:

Please list all of your **current medications** with strength and dosage: A*n attached list is also acceptable*

_____ _____
_____ _____
_____ _____
_____ _____

☐ I have more medications listed on the last page of this form

Please list any medications to which you are **sensitive or allergic:**

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

☐ I have more allergies listed on the last page of this form

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SOCIAL HISTORY:

Please describe your **current profession**: Profession: _____

Employer: _____ Previous Professions: _____

Please describe your **social situation**:

Are you ☐ Married ☐ With significant other ☐ separated ☐ divorced

☐ Widowed ☐ Single ☐ Other _____

Do you have children? If so, Please describe ages _____

Do you have supportive family members in the vicinity of Portland? ☐ Yes ☐ No

Please describe your **smoking history**: ☐ I was never a smoker.

Current smoker of _____ packs per day for the past _____ years

Former smoker of _____ packs per day for _____ year and quit in _____ (year)

☐ I smoke products other than cigarettes, including: _____

Please describe your **alcohol use**. (1 drink = 12 oz beer, 4 oz wine, or 1oz liquor)

☐ Never or rarely drink (less than 1 drink/week) _____ ☐ I drink most days (1 drink/day)

☐ I often drink more than 2 drinks per day and average about _____ drinks/day

☐ I have a personal history of heavy drinking in the past

Please describe any other drug, alcohol or tobacco use in the past 5 years: _____

Please describe your **current fluid intake**. (1 glass or cup in about 8 oz)

I drink about _____ oz of water/non caffeinated fluid daily, usually in the form of _____

I drink about _____ oz of caffeinated fluid daily, usually as _____

Have you noted problems in any of these areas? If so, please provide details.

Unintentional weight loss of _____ lbs over _____ months

Intentional weight loss of _____ lbs over _____ months

Weight gain of _____ lbs over _____ months

Fevers or night sweats _____

Asthma/emphysema/COPD _____

Coughing of blood _____

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Please answer the following questions regarding **heartburn or laryngeal reflux**: *within the past month, how did the following problems affect you?*

0 = No problem 5 = Severe problem	**0**	**1**	**2**	**3**	**4**	**5**
1. Hoarseness or a problem with your voice	☐	☐	☐	☐	☐	☐
2. Clearing your throat	☐	☐	☐	☐	☐	☐
3. Excess throat mucous or postnasal drip	☐	☐	☐	☐	☐	☐
4. Difficulty swallowing food, liquid or pills	☐	☐	☐	☐	☐	☐
5. Coughing after you ate or after lying down	☐	☐	☐	☐	☐	☐
6. Breathing difficulties or choking episodes	☐	☐	☐	☐	☐	☐
7. Troublesome or annoying cough	☐	☐	☐	☐	☐	☐
8. Sensations of something sticking in your throat or a lump in your throat	☐	☐	☐	☐	☐	☐
9. Heartburn, chest pain, indigestion or stomach acid coming up	☐	☐	☐	☐	☐	☐

History of heart murmur _____

History of heart attack _____

History of arrhythmia or palpitations _____

History of stomach ulcers or bleeding _____

History of liver problems or hepatitis _____

History of kidney problems _____

History of bleeding/clotting disorder _____

History of hand, leg or head tremor _____

History of involuntary facial or eye movements _____

History of stroke _____

History of anxiety or depression _____

History of sleep disorder _____

FAMILY HISTORY:

Does anyone in your family have a history of any of the following?

Cancer _____

Thyroid disease _____

Tremor _____

Movement disorder _____

Please use the remaining space to add additional information: