

**Midwestern University – College of Health Sciences
Speech-Language Pathology Program and Speech-Language Institute****Case History: Voice Addendum****Instructions**

Please complete this form and bring with you to your first appointment.

Client Information**Date Completed:****Date of Birth:****First (Preferred) Name:****Last Name:****Voice Concerns**

Please check all that apply.

- Voice sounds harsh/hoarse
- Change in pitch/vocal range
- Breathy voice
- Pain/discomfort with speaking
- “Running out of air” when speaking
- “I can’t get enough air.”
- Vocal fatigue/increased effort to talk
- Unable to initiate a voice
- Difficulty coordinating breathing with speech
- Feeling a “lump” in the throat
- Feeling of throat or chest tightness
- Chronic cough
- Speaking valve use
- Other

Description of concern:**Do your symptoms:**

Please check all that apply.

- Occur during sleep/wake you up from sleeping?
- Occur when you aren’t talking?
- Occur at rest?
- Seem to be stress induced?
- Limit your activities?
- Affect your ability to do your work?
- Affect your ability to complete activities you enjoy?

Voice History

When did your voice symptoms begin?

Were other medical or life events occurring at that time?

- Yes
- No

Have your symptoms:

- Improved
- Worsened
- Remained consistent

Please explain:

Did the symptoms begin:

- Gradually
- Suddenly

Are symptoms worse during certain times of the day?

- Yes
- No

If yes, please describe:

Are symptoms worse in certain environments?

- Yes
- No

If yes, please describe:

Have you ever had a voice evaluation/screening?

- Yes
- No

If yes, where and when?

What were the results?

Have you ever had a study that visualized your vocal folds with an oral or nasal scope?

- Yes
- No

If yes, where and when?

What were the results?

Have you ever been enrolled in voice therapy or are you currently participating in voice therapy?

- Yes
- No

If yes, where?

How long?

Please describe services and progress:

Pertinent Medical History

Do you have a history of acid reflux/GERD? • Yes • No

If yes, what sorts of treatments are you currently using?

Do you feel your reflux is well managed? • Yes • No

Do you still have symptoms? • Yes • No

Have you ever/do you have cancer of the head, neck, or throat? • Yes • No

If yes, please describe its location:

Is it in remission? • Yes • No

When and how was/is it treated (e.g. surgery, radiation, etc)?

Do you have asthma or other respiratory disorders? • Yes • No

If yes, please describe:

Do you have a history of COPD or other respiratory disorders? • Yes • No

If yes, would you consider your COPD to be worsening? • Yes • No

Have you had any recent surgeries/procedures with general anesthesia? • Yes • No

Voice Use

In your job, do you speak extensively (e.g. teacher, clergy, attorney, etc)? • Yes • No

Do you scream (not necessarily in anger), for example, at a sporting event or while working in a noisy environment?

- None
- Less than average
- Average
- More than average

Do you raise your voice (e.g. parenting, calling from room to room, etc)?

- None
- Less than average
- Average
- More than average

Do you talk for long periods of time without a break (teacher, singer, etc)?

- None
- Less than average
- Average
- More than average

Are you a talker?

- None
- Less than average
- Average
- More than average

Do you cough?

- None
- Less than average
- Average
- More than average

Do you clear your throat?

- None
- Less than average
- Average
- More than average

Do you sing?

- None
- Less than average
- Average
- More than average

Please explain:

How often do you use the telephone?

Do you do impersonations, character voices or unusual sound effects?

Please explain:

Vocal Hygiene

Please list how much of the following liquids you drink in ounces per day. 1 cup/glass = 8 oz.

| | | |
|--------|---------------|------------------------|
| Water | Soda | Juice |
| Coffee | Energy Drinks | Sports drinks |
| Tea | Milk | Other (please specify) |

How often do you drink alcoholic beverages (daily, weekly, rarely, never, etc)?

Amount consumed in ounces:

| | | |
|------|------|--------|
| Beer | Wine | Liquor |
|------|------|--------|

Are you currently using tobacco products? • Yes • No

If yes, what type?

How much (packs, cans, etc) per day?

How long have you been using tobacco?

Have you used tobacco in the past? • Yes • No

If yes, what type?

How much (packs, cans, etc) per day?

How long did you use tobacco?

When did you stop?

Are you exposed to secondhand smoke? • Yes • No

If yes, please explain:

Do you use products containing menthol? • Yes • No

If yes, please explain:

Do you take Vitamin C supplements? • Yes • No

If yes, please list amount (mg) per day:

Do you use recreational drugs? • Yes • No

If yes, please list type/amount/frequency:

Additional Swallowing Concerns