Transgender Voice Diagnostic Questionnaire

Name: _____ Referring Doctor:_____
Date of Birth: _____
Address: _____ Phone number: _____
_____ Email: _____

What is your goal regarding voice therapy: _____
_____
Have you ever had a voice disorder or pre-existing medical conditions?:
_____

History:
Occupation: _____
When did you decide to make this change?_____
Are you taking any medications or hormones? YES ☐ NO ☐ If yes, please list. If not, do you plan to take any in the future? _____
Have you had, or are you planning to have, sexual reassignment surgery? YES ☐ NO ☐
explain: _____
Have you seen any professionals in the past? YES ☐ NO ☐
explain: _____
Have you had voice therapy in the past to feminize your voice? YES ☐ NO ☐
explain: _____
Have you tried to feminize your voice on your own? YES ☐ NO ☐
explain: _____
What kind of social experiences/transition status hare you having? (for example, what percent would you say you are in your feminine role and what percent do you spend in masculine role?)
_____
_____
Describe your transition in your own words_____
_____
_____

On a scale of 1 to 7, with 1 being very masculine voice and 7 being very feminine voice, rate your voice.

Masculine Voice						Feminine voice
1	2	3	4	5	6	7

What are you hobbies and interests? _____
In what context are you most concerned about your speech?

Phone ☐	Face-to-Face ☐	Work ☐
Family ☐	Friends ☐	Strangers ☐

Please check **all** the following symptoms that apply to you:

Breathiness ☐
Roughness ☐
Gravelly voice quality ☐
Harsh voice quality ☐
Raspy voice quality ☐
Scratchy voice quality ☐
Shaky voice ☐
Unsteady voice ☐
Voice breaks ☐
Pitch breaks ☐
Voice too high ☐
Voice too low or deep ☐
Difficulty speaking loudly ☐
Difficulty speaking softly ☐

Voice too loud ☐
Voice too soft ☐
Whisper only (total loss of voice) ☐
Straining to speak ☐
Vocal fatigue ☐
Throat pain ☐
Nasality ☐
Noisy breathing ☐
Excessive throat mucus ☐
Foreign body sensation in throat ☐
Heartburn ☐
Indigestion ☐

Bitter or metallic taste after waking ☐
Sudden coughing after lying down ☐
Chronic throat clearing ☐
Chronic cough ☐
Halitosis ☐
Worse voice when you wake ☐
Increased or chronic post nasal drip ☐
Tooth decay ☐
Chronic bronchitis ☐

Do you feel it takes effort to speak? YES ☐ NO ☐ If yes, please explain when this occurs and how long it lasts_____
Can you be heard over ambient noise? YES ☐ NO ☐
Do others often ask you to repeat? YES ☐ NO ☐
How often do you experience reflux symptoms? Daily ☐ Weekly ☐ Monthly ☐
When reflux occurs, how do you treat it?_____
Do you have any pain and/or tension in your jaw, neck, or shoulders? YES ☐ NO ☐ If yes, please circle one to describe: sharp, stabbing pain, dull muscular ache, or a raw pain
Have you ever had surgery for this or any other voice related condition? YES ☐ NO ☐
If yes, please list dates, location, therapists and results of therapy._____
Have you had any choking or swallowing problems? YES ☐ NO ☐ If yes, please explain how often, when, and with what food or drink consistencies._____
Do you have pain when swallowing? YES ☐ NO ☐
Have you had any recent surgeries? YES ☐ NO ☐ If yes, explain._____
_____
Have you had any recent neck injuries?- YES ☐ NO ☐ If yes, please explain._____
_____Have you ever worked around any toxic fumes (gas, paints, chemicals)? YES ☐ NO ☐ If yes, please explain_____
List current neurological problems (diagnoses and dates)._____
_____
Do you have a known (diagnosed) hearing loss? YES ☐ NO ☐
If yes, do you or have you ever worn hearing aids? YES ☐ NO ☐

Social History:

Circle one: I am single married widowed
Do you live alone? YES ☐ NO ☐ If no, with whom?_____

Do you have children? YES ☐ NO ☐ If so, please list how many and if you have grandchildren._____
Please list your education level._____

General Medical Health:

Arthritis ☐	High Blood Pressure ☐	Depression ☐
Asthma (adult/childhood onset) ☐	Kidney/Bladder Disease ☐	Bleeding Problems ☐
Bronchitis ☐	Liver Disease ☐	Stroke ☐
Blood sugar (high/low) ☐	Lung Disease ☐	GI Disorders (hernia ulcers, colitis, etc.) ☐
Diabetes (adult/childhood onset) ☐	Joint/Bone Disease ☐	Sinus Disease ☐
Headaches ☐	Tuberculosis ☐	Endocrine Disorder ☐
Heart disease ☐	Cancer ☐	
	Thyroid Disease ☐	
	Neurologic Disorders ☐	

Other:_____
_____
_____
Do you have allergies to foods? Drugs? Environments? _____
_____

Vocal Use:

**Please answer the following questions using this scale: 0 = none, 1 = less than average, 2 = average, 3 = more than average.*

Do you scream (not necessarily in anger, for example, at a sporting event or while working in a noisy environment)? 0 1 2 3
Do you raise your voice (e.g. parenting, calling from room to room, etc)? 0 1 2 3
Do you talk for long periods of time without a break (teacher or singer)? 0 1 2 3
Are you a "talker"? 0 1 2 3
Do you clear your throat? 0 1 2 3
Do you cough? 0 1 2 3
Do you sing? 0 1 2 3 If yes, please explain._____
How often do you use the telephone 0 1 2 3
Do you do impersonations, character voices or unusual sound effects? 0 1 2 3

If yes, please explain._____
Please list any hobbies or activities you enjoy._____
Do you grunt when you exercise? YES/NO
Do you talk when you're stressed? YES/NO
Do you talk when you are tired? YES/NO
Do you talk at a low pitch? YES/NO
Do you talk at a high pitch? YES/NO
Do you talk when you are sick with any kind of upper respiratory infection? YES/NO

Vocal Hygiene:

What is your current weight? _____lbs

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

Water____ Coffee_____ Tea_____ Soda_____ Energy Drinks_____ Milk_____ Juice_____

Sports Drinks_____ Other (please specify)_____

I drink alcoholic beverages (circle one) daily weekly rarely never

Amount in ounces: Beer_____ Wine_____ Liquor _____

Are you currently using tobacco products? YES/NO If yes, what type_____

How much (packs/cans/etc.) per day? _____ For how long?_____

Have you used tobacco products in the past? YES/NO If yes, what type_____

How much (packs/cans/etc.) per day? _____ For how long?_____

Date of cessation_____

Are you exposed to secondhand smoke? YES/NO If yes, please explain._____

Do you use products containing menthol? YES/NO If yes, please list._____

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, and frequency. _____

_____

Please list current medications (over the counter and prescription.)

_____**NONE**

Medication	**Condition**
1. _____	for _____
2. _____	for _____
3. _____	for _____
4. _____	for _____
5. _____	for _____
6. _____	for _____
7. _____	for _____
8. _____	for _____
9. _____	for _____
10. _____	for _____

Would you like this report sent to anyone other than the referring physician? If so, please list name and contact information. _____

_____

_____

_____ _____

Patient Signature Date

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EAR NOSE & THROAT

REFLUX SYMPTOM INDEX (RSI)

PLEASE RATE HOW THE FOLLOWING PROBLEMS HAVE AFFECTED YOU WITHIN THE LAST MONTH, USING A ZERO-TO-FIVE SCALE, WHERE:

***0= NO PROBLEM** AND **5=SEVERE PROBLEM**.*

1. Hoarseness or a problem with you voice	0 1 2 3 4 5
2. Clearing your throat	0 1 2 3 4 5
3. Excess throat mucous or postnasal drip	0 1 2 3 4 5
4. Difficulty swallowing food, liquids or pills	0 1 2 3 4 5
5. Coughing after you ate or after lying down	0 1 2 3 4 5
6. Breathing difficulties or choking episodes	0 1 2 3 4 5
7. Troublesome or annoying cough	0 1 2 3 4 5
8. Sensations of something sticking in your throat or a lump in your throat	0 1 2 3 4 5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0 1 2 3 4 5

TOTAL:_____

Belafsky PC, Postma GN, Koufman JA. Validity and reliability of the reflux symptom index (RSI). J Voice. 2002 Jun;16(2):274-7.

VOICE HANDICAP INDEX

Name:_____ **Date:**_____

I need active use of my speaking voice primarily for
- □ A. my profession (teacher, minister, lawyer, etc)
- □ B. activities outside work (coaching, community, etc)
- □ C. normal everyday conversation

I need active use of my singing voice primarily for:
- □ A. my profession (singer – primary income, student of voice)
- □ B. activities outside work (choir/chorus, singer/band)
- □ C. none of the above. I do not sing.

Total = _____

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

To be filled out by Voice Staff

P Spk □
NPV □

VHI F=_____
P=_____
E=_____

P Sing □
R Sing □

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

0=Never 1=Almost Never 2= Sometimes 3=Almost Always 4=Always

Part I-F

1. My voice makes it difficult for people to hear me.	0 1 2 3 4
2. People have difficulty understanding me in a noisy room.	0 1 2 3 4
3. My family has difficulty hearing me when I call them throughout the house.	0 1 2 3 4
4. I use the phone less often than I would like to.	0 1 2 3 4
5. I tend to avoid groups of people because of my voice.	0 1 2 3 4
6. I speak with friends, neighbors, or relatives less often because of my voice.	0 1 2 3 4
7. People ask me to repeat myself when speaking face-to-face.	0 1 2 3 4
8. My voice difficulties restrict personal and social life.	0 1 2 3 4
9. I feel left out of conversations because of my voice.	0 1 2 3 4
10. My voice problem causes me to lose income.	0 1 2 3 4

Part II-P

1. I run out of air when I talk.	0 1 2 3 4
2. The sound of my voice varies throughout the day.	0 1 2 3 4
3. People ask, “What’s wrong with your voice?”	0 1 2 3 4
4. My voice sounds creaky and dry.	0 1 2 3 4
5. I feel as though I have to strain to produce voice.	0 1 2 3 4
6. The clarity of my voice is unpredictable.	0 1 2 3 4
7. I try to change my voice to sound different.	0 1 2 3 4
8. I use a great deal of effort to speak.	0 1 2 3 4
9. My voice is worse in the evening.	0 1 2 3 4
10. My voice “gives out” on me in the middle of speaking.	0 1 2 3 4

Part III-E

1. I am tense when talking to others because of my voice.	0 1 2 3 4
2. People seem irritated with my voice.	0 1 2 3 4
3. I find other people don’t understand my voice problem.	0 1 2 3 4
4. My voice problem upsets me.	0 1 2 3 4
5. I am less outgoing because of my voice problem.	0 1 2 3 4
6. My voice makes me feel handicapped.	0 1 2 3 4
7. I feel annoyed when people ask me to repeat.	0 1 2 3 4
8. I feel embarrassed when people ask me to repeat.	0 1 2 3 4
9. My voice makes me feel incompetent.	0 1 2 3 4
10. I am ashamed of my voice problem.	0 1 2 3 4

The Voice Handicap Index (VHI): Development and Validation
Jacobsen B, Johnson A, Grywalski C, Silbergleit A, Jacobson G, Benninger M
American Journal of Speech-Language Pathology, Vol 6(3), 66-70, 1997

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EAR NOSE & THROAT

TVQ MtF

Rating Scale
1 = never or rarely
2 = sometimes
3 = often
4 = usually or always

Name: _____

Date: _____

Based on your actual experience of living as a female, please tick the response that fits you best.

		1	2	3	4
1.	People have difficulty hearing me in a noisy room.	☐	☐	☐	☐
2.	I feel anxious when I know I have to use my voice.	☐	☐	☐	☐
3.	My voice makes me feel less feminine than I would like.	☐	☐	☐	☐
4.	The pitch of my speaking voice is too low.	☐	☐	☐	☐
5.	The pitch of my voice is unreliable.	☐	☐	☐	☐
6.	My voice gets in the way of me living as a woman.	☐	☐	☐	☐
7.	I avoid using the phone because of my voice.	☐	☐	☐	☐
8.	I'm tense when talking with others because of my voice.	☐	☐	☐	☐
9	My voice gets croaky, hoarse or husky when I try to speak in a female voice.	☐	☐	☐	☐
10.	My voice makes it hard for me to be identified as a woman.	☐	☐	☐	☐
11.	When I speak the pitch of my voice does not vary enough.	☐	☐	☐	☐
12.	I feel uncomfortable talking to friends, neighbours and relatives because of my voice.	☐	☐	☐	☐
13.	I avoid speaking in public because of my voice.	☐	☐	☐	☐
14.	My voice sounds artificial.	☐	☐	☐	☐
15.	I have to concentrate to make my voice sound the way I want it to sound.	☐	☐	☐	☐
16.	I feel frustrated with trying to change my voice.	☐	☐	☐	☐
17.	My voice difficulties restrict my social life.	☐	☐	☐	☐
18.	When I am not paying attention my pitch goes down.	☐	☐	☐	☐
19.	When I laugh I sound like a man.	☐	☐	☐	☐
20.	My voice doesn't match my physical appearance.	☐	☐	☐	☐
21.	I use a great deal of effort to produce my voice.	☐	☐	☐	☐
22.	My voice gets tired quickly.	☐	☐	☐	☐
23.	My voice restricts the sort of work I do.	☐	☐	☐	☐
24.	I feel my voice does not reflect the 'true me'.	☐	☐	☐	☐
25.	I am less outgoing because of my voice.	☐	☐	☐	☐
26.	I feel self-conscious about how strangers perceive my voice.	☐	☐	☐	☐
27.	My voice 'gives out' in the middle of speaking.	☐	☐	☐	☐
28.	It distresses me when I'm perceived as a man because of my voice.	☐	☐	☐	☐
29.	The pitch range of my speaking voice is restricted.	☐	☐	☐	☐
30.	I feel discriminated against because of my voice.	☐	☐	☐	☐

Please provide an overall rating of your voice:

Currently, my voice is:	☐ Very female	☐ Somewhat female	☐ Gender neutral	☐ Somewhat male	☐ Very male
My ideal voice would sound:	☐ Very female	☐ Somewhat female	☐ Gender neutral	☐ Somewhat male	☐ Very male

Consent to Perform Videostroboscopy

Client Name: _____

I hereby consent to and authorize the performance of videostroboscopy for assessment of vocal fold structure and functioning to be performed at Fort Worth ENT.

Initial: _____

I consent to the administration of topical anesthetic, if required. I have no known allergies and/or medical conditions that prohibit the use of topical anesthetics.

Initial: _____

The nature and purpose of the procedures and the potential risks involved have been explained to me. Potential risks include allergic reaction to topical anesthetic, bleeding (transnasal endoscopy only), and/or temporary discomfort. No guarantee or assurance has been given by anyone as to the results that may be obtained.

Initial: _____

I understand that all information pertaining to services at Fort Worth ENT is kept confidential and will be made available to other professional personnel only after I have signed an Authorization to Send/Release Information form.

Initial: _____

Fort Worth ENT may participate in research and social media projects to expand knowledge of clinical outcomes in the treatment and evaluation of voice and voice disorders. Further, I understand that audio and/or videotapes of sessions and other case information may be used in these research projects. If I choose not to have my information included in research and social media projects, I do not have to initial here.

Initial: _____

_____ _____

Signature of Client/Parent or Guardian *Date Signed*