Voice Diagnostic Packet

Name: _____ Referring Doctor:_____Follow up scheduled? YES ☐ NO ☐
Date of Birth: _____ Diagnosis: _____
Address: _____ Phone number: _____
_____ Email: _____

What is your goal regarding your problem or condition: _____

History:
Occupation: _____ When did your voice problem begin?_____
My voice problem started: ☐ suddenly ☐ gradually
Describe your voice problem in your own words_____
What bothers you most about your voice problem?_____

Please check all the following symptoms that apply to you:

Breathiness ☐	Voice too loud ☐	Bitter or metallic taste
Roughness ☐	Voice too soft ☐	after waking ☐
Gravelly voice quality ☐	Whisper only (total loss of	Sudden coughing after
Harsh voice quality ☐	voice) ☐	lying down ☐
Raspy voice quality ☐	Straining to speak ☐	Chronic throat clearing ☐
Scratchy voice quality ☐	Vocal fatigue ☐	Chronic cough ☐
Shaky voice ☐	Throat pain ☐	Halitosis ☐
Unsteady voice ☐	Nasality ☐	Worse voice when you
Voice breaks ☐	Noisy breathing ☐	wake ☐
Pitch breaks ☐	Excessive throat mucus ☐	Increased or chronic post
Voice too high ☐	Foreign body sensation in	nasal drip ☐
Voice too low or deep ☐	throat ☐	Tooth decay ☐
Difficulty speaking loudly ☐	Heartburn ☐	Chronic bronchitis ☐
Difficulty speaking softly ☐	Indigestion ☐	

Swallowing difficulty YES ☐ NO ☐
Increased voice use YES ☐ NO ☐
Emotional stress YES ☐ NO ☐
Vocal Overuse (yelling/screaming) YES ☐ NO ☐
Around toxic fumes (gas, paint, chemicals) YES ☐ NO ☐
Similar voice problems in your past: YES ☐ NO ☐
Voice has returned to normal ever: YES ☐ NO ☐
Does voice rest help your voice? YES ☐ NO ☐
Can you be heard over ambient noise? YES ☐ NO ☐
Has the problem interfered with work? YES ☐ NO ☐
Do you experience reflux symptoms? YES ☐ NO ☐
Choking or swallowing problems? YES ☐ NO ☐
My voice is worse in the: Morning ☐ Evening ☐

Injury (trauma) YES ☐ NO ☐
Upper respiratory infection YES ☐ NO ☐
Surgery YES ☐ NO ☐
Surgery for voice related condition YES ☐ NO ☐
Recent Neck Injuries YES ☐ NO ☐
It takes effort to speak: YES ☐ NO ☐
Problem worsens the more I talk: YES ☐ NO ☐
Does anything help your voice? YES ☐ NO ☐
Do others often ask you to repeat? YES ☐ NO ☐
Upper body pain/tension? YES ☐ NO ☐
Do you treat your reflux symptoms? YES ☐ NO ☐
Do you have pain when swallowing? YES ☐ NO ☐
Seasonal changes affect my voice? YES ☐ NO ☐

Do you participate in fewer social activities since your current difficulty began? YES ☐ NO ☐

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(Please See Reverse Side)

_____
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Social History:

I am ☐ single ☐ married ☐ widowed
Do you live alone? YES ☐ NO ☐
Do you have children? YES ☐ NO ☐
Education ☐ High School/GED ☐ College

General Medical Health:

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

Other:_____
List Allergies: _____
For females only:
Are you pregnant? YES ☐ NO ☐
Have you gone through menopause? YES ☐ NO ☐
Do you have regular menstrual cycles? YES ☐ NO ☐
Voice change during your menstrual cycle? YES ☐ NO ☐

Vocal Use:

Are you a "talker"? YES ☐ NO ☐
Do you clear your throat? YES ☐ NO ☐
Do you cough? YES ☐ NO ☐
Do you sing? YES ☐ NO ☐
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 use the telephone often? YES ☐ NO ☐
Do you talk for long periods with no break YES ☐ NO ☐
Do you scream YES ☐ NO ☐
Do you do impersonations, character voices or unusual sound effects? YES ☐ NO ☐
Do you talk when you are sick with any kind of upper respiratory infection? YES ☐ NO ☐
Do you raise your voice (e.g. parenting, calling from room to room, etc)? 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 ☐NEVER ☐ daily ☐ weekly ☐ rarely ---- Beer__ oz Wine____oz Liquor __oz
I currently use tobacco products: YES ☐ NO ☐ ---------- Cigarettes ☐ Snuff ☐ Vapor Cigarettes ☐ Pipe ☐
How much (packs/cans/etc.) per day? _____ How many years?_____
I have used tobacco products in the past? YES ☐ NO ☐ ------ Cigarettes ☐ Snuff ☐ Vapor Cigarettes ☐ Pipe ☐
Packs/cans/etc. per day? _____ For how long?_____ years Date of Cessation_____
Are you exposed to secondhand smoke? YES ☐ NO ☐
I use products containing menthol? YES ☐ NO ☐
Do you take Vitamin C supplements? YES ☐ NO ☐
Do you use recreational drugs? YES ☐ NO ☐

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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.

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Voice Diagnostic Packet

PEDIATRIC VOICE HANDICAP INDEX (pVHI)

Name: _____ Date: ___/___/_____

Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Please circle the response that indicates how frequently your child experiences the same symptoms (0=never, 1=almost never, 2=sometimes, 3=almost always, 4=always)

FMy child's voice makes it difficult for people to hear him/her.	0 1 2 3 4
People have difficulty understanding my child in a noisy room.	0 1 2 3 4
At home, we have difficulty hearing our child when he/she calls through the house.	0 1 2 3 4
My child tends to avoid communicating because of his/her voice.	0 1 2 3 4
My child speaks with friends, neighbors, or relatives less often because of his/her voice.	0 1 2 3 4
People ask my child to repeat him/herself when speaking face-to-face.	0 1 2 3 4
My child's voice difficulties restrict personal, educational and social activities	0 1 2 3 4
PMy child runs out of air when talking.	0 1 2 3 4
The sound of my child's voice changes throughout the day	0 1 2 3 4
People ask, "What's wrong with your child's voice?"	0 1 2 3 4
My child's voice sounds dry, raspy, and/or hoarse.	0 1 2 3 4
The quality of my child's voice is unpredictable.	0 1 2 3 4
My child uses a great deal of effort to speak (e.g., straining).	0 1 2 3 4
My child's voice is worse in the evening.	0 1 2 3 4

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My child's voice "gives out" when speaking.	0 1 2 3 4
My child has to yell in order for others to hear him/her.	0 1 2 3 4
EMy child appears tense when talking with others because of his/her voice.	0 1 2 3 4
People seem irritated with my child's voice.	0 1 2 3 4
I find other people don't understand my child's voice problem.	0 1 2 3 4
My child is frustrated with his/her voice problem.	0 1 2 3 4
My child is less out-going because of his/her voice problem.	0 1 2 3 4
My child is annoyed when people ask him/her to repeat.	0 1 2 3 4
My child is embarrassed when people ask him/her to repeat.	0 1 2 3 4

I would rate my child's talkativeness as the following:

1	2	3	4	5	6	7

Quiet listener — Average Talker — Extremely Talkative

Overall Severity Rating of Voice
(Please place "X" mark anywhere along this line to indicate the severity of your child's voice problem.)

Normal — Severe

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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*

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_____

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