fort worth ent
EAR NOSE & THROAT

Vocal Cord Dysfunction/Chronic Cough Questionnaire

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

PLEASE ANSWER THE FOLLOWING QUESTIONS:
1. Students: Name of school: _____ Grade _____

Extracurricular activities: sports cheerleading choir drama
Other: _____

2. When did your current breathing/coughing problem begin?

My breathing/coughing problem started (circle one) gradually suddenly

What do you think caused your present breathing/coughing problem?

Is it getting: Worse ____. Better_____. Same_____.

Can you do anything that helps make it better? YES □ NO □

Do you have asthma or any other respiratory problem? YES □ NO □ If yes, when was it diagnosed?

Do you have allergies? YES □ NO □ If yes, please list (include environmental, foods, and/or drugs.)

3. Which of these statements best describes your breathing/coughing problems?

I can't get enough air.	YES	NO	SOMETIMES
I run out of air while speaking.	YES	NO	SOMETIMES
My chest feels tight.	YES	NO	SOMETIMES
My throat feels tight.	YES	NO	SOMETIMES
I can't coordinate my breathing with my speech.	YES	NO	SOMETIMES
This is different than asthma.	YES	NO	SOMETIMES
This is the same as asthma but my inhalers don't work.	YES	NO	SOMETIMES

Breathing medications/inhalers

are helpful for me.	YES	NO	SOMETIMES
Allergy medications are helpful for my breathing/cough.	YES	NO	SOMETIMES
Nothing I do helps my breathing.	YES	NO	SOMETIMES

4. Which of these are related to your breathing/coughing difficulties?

_____Occurs during sleep/wakes me up from sleeping
_____Occurs at rest
_____Stress induced
_____Co-occurs with coughing
_____Limits activities

5. Circle any of the following that cause breathing/coughing difficulties:

Strong perfume/lotions	Candles	Potpourri
Extreme environmental temperature changes		Gasoline
Cleaning solutions (e.g., bleach/Tilex/Pine sol)		High levels of humidity
Cigarette Smoke	Car exhaust	Newspaper Print
Laughing	Exercise	Talking
Singing	Pool chemicals	Other: _____

Is there a family history of asthma or allergies? YES □ NO □

Is it more difficult to inhale or exhale when your problems are exacerbated?

Do you make noise when you inhale? YES □ NO □

How long do you experience difficulty breathing/coughing? (Does it go away after a few minutes or last 5-10 minutes or longer?)

How many times per day do you have the coughing/breathing problem?

Do you ever cough/wheeze during or after exercising? YES ☐ NO ☐ If yes, how long can you exercise aerobically (walk, run) before triggering the breathing/coughing problem?

Do you have voice changes with your breathing/cough? YES ☐ NO ☐ explain: (higher pitch, voice is rougher, etc.) _____

What is your estimate of the severity of the problem? (circle one) mild moderate severe

What other individuals recognize the problem?

Does the severity of the breathing problem/cough change with any of the following factors:

Season_____
Geographic location_____
Weather_____
Fatigue_____
Mood_____

Have you ever personally tried to do anything to correct this problem? If so, explain.

6. Do you have any of the following swallowing problems?

_____ choking, coughing, or throat clearing while eating
_____ choking, coughing, or throat clearing while drinking cold or hot drinks
_____ choking, coughing, or throat clearing while eating spicy foods
_____ choking, coughing, or throat clearing while at rest

If you choke, how frequently does it occur?

7. During the PAST MONTH have you often experienced any of the following?

_____ Stomach pain
_____ Back pain
_____ Pain in your arms, legs, or joints
_____ Headaches
_____ Chest pains
_____ Dizziness
_____ Fainting spells
_____ Feeling your heart pound or race
_____ Constipation or diarrhea
_____ Nausea, gas, heartburn, or indigestion
_____ Bitter or acid taste after waking
_____ Frequent bad breath

_____ Tickling or choking sensation in throat
_____ Burping
_____ Burning sensation in throat
_____ Feeling tired or having low energy
_____ Trouble sleeping
_____ An anxiety attack
_____ Problems with family, friends, co-workers, finances, school
_____ Exposure to smoke or fumes

8. Do you have any neurological problems (tremor, Parkinson's disease)? YES ☐ NO ☐
Explain: _____

9. Have you had any emotional problems that were treated by a psychologist or psychiatrist or by medication? YES ☐ NO ☐

10. Are you/your family under high levels of stress/tension? YES ☐ NO ☐

11. How has this breathing/coughing problem affected your social life? YES ☐ NO ☐

12. Have you ever had surgery? YES ☐ NO ☐ If yes, please list the date and type.

13. Do you have any problems with your voice? YES ☐ NO ☐ (if no, go on to question 15)

My voice problem came on: (circle one) slowly suddenly
Did it begin before or after your breathing problems began? before after
Is it different when you have breathing problems? YES ☐ NO ☐

14. Do you experience any of the following?
_____ Hoarseness
_____Vocal fatigue
_____Increased effort to talk
_____Volume disturbance (too soft _____ too loud _____)
_____Loss of range (high _____ low _____)
_____Breathiness
_____Voice worse in the morning
_____Voice worse later in the day, after it has been used
_____Pain in throat while speaking or singing
_____Jaw joint problems
_____Speak extensively (e.g., teacher, clergy, attorney, telephone work) ****

*****IF YES, WE WOULD LIKE TO ASK YOU TO COMPLETE AN ADDITIONAL FORM DESIGNED ESPECIALLY FOR PROFESSIONAL VOICE USERS:**

**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

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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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.

DYSPNEA SEVERITY INDEX (DSI)

Name: _____ Date: ___/___/_____

These are some symptoms that you may be feeling. Please circle the response that indicates how frequently you experience the same symptoms (0=never, 1=almost never, 2=sometimes, 3=almost always, 4=always)

I have trouble getting air in.	0 1 2 3 4
My breathing problem causes me to restrict my personal and social life.	0 1 2 3 4
My shortness of breath gets worse with stress.	0 1 2 3 4
The change in weather affects my breathing problem.	0 1 2 3 4
My breathing gets worse with stress.	0 1 2 3 4
I have to strain to breathe.	0 1 2 3 4
It takes more effort to breathe than it used to.	0 1 2 3 4
My breathing problem upsets me	0 1 2 3 4
My shortness of breath scares me	0 1 2 3 4
My breathing problem makes me feel stressed	0 1 2 3 4

What is your perception of the severity of your breathing problem?

1	2	3	4	5	6	7

Least severe Most severe

VOCAL CORD DYSFUNCTION QUESTIONNAIRE (VCDQ)

Name: _____ Date: ___/___/_____

Instructions: These are statements that many people have used to describe breathing difficulty has on their lives. Please circle the response that indicates how you experience the same symptoms (0=strongly disagree, 1=disagree, 2=neither agree nor disagree, 3=agree, 4=agree, 5=agree strongly)

My symptoms are confined to my throat/upper chest	0 1 2 3 4 5
I feel like I can't get breath past a certain point in my throat/upper chest area because of restriction	0 1 2 3 4 5
My breathlessness is usually worse when breathing in	0 1 2 3 4 5
My attacks typically come on very suddenly	0 1 2 3 4 5
I feel that there is something in my throat that I can't clear	0 1 2 3 4 5
My attacks are associated with changes in my voice	0 1 2 3 4 5
My breathing can be noisy during attacks	0 1 2 3 4 5
I am aware of other specific triggers that cause attacks	0 1 2 3 4 5
My symptoms are associated with an ache or itch in my throat	0 1 2 3 4 5
I am frustrated that my symptoms have not been understood correctly	0 1 2 3 4 5
I am unable to tolerate any light pressure around my neck, e.g. tight clothes or bending the neck	0 1 2 3 4 5
The attacks impact on my social life	0 1 2 3 4 5

What is your perception of the severity of your breathing problem?

1	2	3	4	5	6	7

Least severe Most severe

Fowler, SJ; Thurston, A; Chesworth, B; Cheng, V; Constantinou, P; Vyas,A'Lillie,S' Haines,J.; The VCDQ- a Questionnaire for symptom monitoring in vocal cord dysfunction. Clinical & Experimental Allergy 45, 1405-1411, 2015

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*