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

1
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.

<table>
<thead>
<tr>
<th>Drink</th>
<th>Water</th>
<th>Coffee</th>
<th>Tea</th>
<th>Soda</th>
<th>Energy Drinks</th>
<th>Milk</th>
<th>Juice</th>
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<tbody>
<tr>
<td>Ounces per Day</td>
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</table>

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

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

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.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Condition</th>
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<tbody>
<tr>
<td>1.</td>
<td>for NONE</td>
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<tr>
<td>2.</td>
<td>for NONE</td>
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<td>3.</td>
<td>for NONE</td>
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<td>4.</td>
<td>for NONE</td>
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<td>5.</td>
<td>for NONE</td>
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<td>6.</td>
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<td>8.</td>
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<td>9.</td>
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<td>10.</td>
<td>for NONE</td>
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</table>

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

______________________________________________________

Patient Signature

Date
REFLUX SYMPTOM INDEX (RSI)

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

\[ 0 = \text{NO PROBLEM AND 5=SEVERE PROBLEM.} \]

1. Hoarseness or a problem with your 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: __________

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.  

My breathing problem causes me to restrict my personal and social life.  

My shortness of breath gets worse with stress.  

The change in weather affects my breathing problem.  

My breathing gets worse with stress.  

I have to strain to breathe.  

It takes more effort to breathe than it used to.  

My breathing problem upsets me  

My shortness of breath scares me  

My breathing problem makes me feel stressed  

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

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<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td></td>
<td>Least severe</td>
<td>Most severe</td>
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</table>
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)

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

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<th>7</th>
</tr>
</thead>
</table>
| 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