

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

- | | |
|---|--|
| Swallowing difficulty YES <input type="checkbox"/> NO <input type="checkbox"/> | Injury (trauma) YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Increased voice use YES <input type="checkbox"/> NO <input type="checkbox"/> | Upper respiratory infection YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Emotional stress YES <input type="checkbox"/> NO <input type="checkbox"/> | Surgery YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Vocal Overuse (yelling/screaming) YES <input type="checkbox"/> NO <input type="checkbox"/> | Surgery for voice related condition YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Around toxic fumes (gas, paint, chemicals) YES <input type="checkbox"/> NO <input type="checkbox"/> | Recent Neck Injuries YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Similar voice problems in your past: YES <input type="checkbox"/> NO <input type="checkbox"/> | It takes effort to speak: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Voice has returned to normal ever: YES <input type="checkbox"/> NO <input type="checkbox"/> | Problem worsens the more I talk: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Does voice rest help your voice? YES <input type="checkbox"/> NO <input type="checkbox"/> | Does anything help your voice? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Can you be heard over ambient noise? YES <input type="checkbox"/> NO <input type="checkbox"/> | Do others often ask you to repeat? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Has the problem interfered with work? YES <input type="checkbox"/> NO <input type="checkbox"/> | Upper body pain/tension? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Do you experience reflux symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/> | Do you treat your reflux symptoms? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Choking or swallowing problems? YES <input type="checkbox"/> NO <input type="checkbox"/> | Do you have pain when swallowing? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| My voice is worse in the: Morning <input type="checkbox"/> Evening <input type="checkbox"/> | Seasonal changes affect my voice? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Do you participate in fewer social activities since your current difficulty began? YES <input type="checkbox"/> NO <input type="checkbox"/> | |

Voice Diagnostic Packet

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

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

Hearing Loss

Thyroid 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

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.*

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)

My 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

My 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

Voice Diagnostic Packet

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

My 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

Voice Diagnostic Packet

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