REQUIRED - ENTIRE FORM MUST BE COMPLETED*

Baylor Scott & White The Voice Center

Lindsey C. Arviso, M.D.

PATIENT QUESTIONNAIRE

PATIENT NAME:_____ **DATE:**_____

Date of Birth: _____ Age:_____ Height:_____ Weight:_____ Gender: Male _____ Female _____

Marital Status:_____ Occupation:_____ Referring Physician:_____

Primary Care Doctor: _____ Pediatrician: _____

REASON FOR CURRENT DOCTOR VIST: Explain problem/s and duration: _____

_____

PERSONAL MEDICAL HISTORY: Please check all that apply: [] None Apply

[] High blood pressure
[] Diabetes
[] Thyroid disease
[] Heart disease
[] Infectious Disease (HIV, TB, Hepatitis, etc): _____
[] Lung Disease (Asthma, Emphysema, etc): _____
[] Cancer: _____
[] Other (List) _____

REVIEW OF SYSTEMS: Check the appropriate box; if yes, explain briefly below

[] Vision problems
[] Lung problems
[] Heart problems
[] Kidney problems
[] Liver problems
[] Stomach problems
[] Bleeding problems
[] Endocrine problems
[] Musculoskeletal problems
[] Neurologic problems
[] Psychiatric problems
[] Skin problems

Explain if yes: _____

PRIOR SURGERIES: Please list with dates

[] No surgeries

_____
_____
_____

FAMILY HISTORY: List family member and as related to your current problem

_____
_____
_____

MEDICATIONS: [] No Medications

Medication Dose How often taken

_____
_____
_____
_____
_____

Please list others on the back of this sheet

ALLERGIES TO MEDICINES: [] No Allergies

List medicine and reaction

_____
_____
_____

Are you pregnant: [] Yes [] No

If yes, how many months? _____

SOCIAL HISTORY:

City of Birth: _____How long in TX_____

Do you smoke? Y/N If yes, # of packs/day?____ How many years?___

If no, have you ever smoked?_____ When did you quit?_____

Do you drink alcohol? Y/N If yes, how much, how often?_____

PHARMACY:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Patient Signature: _____

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Lindsey Arviso, M.D.

Voice Center New Patient Questionnaire

Date: _____

Patient Name: _____ DOB: _____

1. What is the reason for your visit today? _____
2. When did your symptoms start? _____
3. Were there any associated illness, factors, or conditions at the time of onset?

   _____

4. How would you describe your symptoms?
   - o Mild
   - o Moderate
   - o Severe
   - o Sudden onset
   - o Gradual onset

5. Do you have any of the following symptoms?
   - o Hoarseness
   - o Fullness in throat
   - o Difficulty swallowing
   - o Difficulty breathing
   - o Throat pain
   - o Noisy breathing
   - o Burning sensation in throat
   - o Excessive throat mucus
   - o Feeling something stuck in throat
   - o Heartburn/regurgitation
   - o Chronic cough
   - o Throat clearing
   - o Voice Change

6. How much do you drink of the following per day?
   - o Caffeine per day _____
   - o Water per day _____

7. Have you had any of the following studies in the past?
   - o Pulmonary function test
   - o Laryngoscopy
   - o Methacholine challenge test
   - o Modified Barium Swallow
   - o Esophagram
   - o Upper GI/ Esophagoscopy
   - o FEES
   - o Speech Therapy
   - o Chest X-ray

8. If hoarse, how does this impact your life? _____
9. If having difficulty swallowing, what foods/liquids are problematic?

   _____

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VOICE HANDICAP INDEX-10 (VHI-10)

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 you experience the same symptoms.
(0 = never, 1 = almost never, 2 = sometimes, 3 = almost always, 4 = always)

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 voice difficulties restrict my personal and social life.	0	1	2	3	4
4.	I feel left out of conversations because of my voice.	0	1	2	3	4
5.	My voice problem causes me to lose income.	0	1	2	3	4
6.	I feel as though I have to strain to produce voice.	0	1	2	3	4
7.	The clarity of my voice is unpredictable.	0	1	2	3	4
8.	My voice problem upsets me.	0	1	2	3	4
9.	My voice makes me feel handicapped.	0	1	2	3	4
10.	People ask, "What's wrong with your voice?"	0	1	2	3	4

SCORE: _____

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

1	2	3	4	5	6	7

Least Severe Most Severe