Otolaryngology Voice Evaluation Intake Form

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Please fill out the following pages.
If something does not apply to you
leave it blank or write N/A.

AT THE FOREFRONT
UChicago Medicine

Voice Evaluation

Patient Sticker

Name	**Date**
Date of Birth	**Phone Number**
Referring MD	
Primary Care Physician	

What gender pronoun do you prefer? (check one)

☐ She and Her ☐ He and His ☐ They and Them

Social History

Occupation (work):

Educational history:

Languages spoken:

Medical History: (Check all that apply)

☐ Heart problems (What kind)
_____

☐ Stroke or transient ischemic attack

☐ Diabetes

☐ High blood pressure

☐ Thyroid problems

☐ Kidney disease. If you have kidney disease, do you get dialysis?
☐ Yes ☐ No

☐ Other medical problems (please list):

☐ Gastro-Esophageal Reflux (GERD)

☐ Lung disease

☐ Cancer (What kind)
_____

☐ Arthritis

☐ Allergic rhinitis (runny nose)

☐ Chronic sinusitis (pressure around your nose)

☐ Depression, anxiety, mood disorder

Surgical History: (Check all that apply)

☐ Heart surgery

☐ Thyroid or Parathyroid surgery

☐ Lung surgery

☐ Other (please list):

☐ Spine surgery

☐ Sinus surgery

☐ Orthopedic surgery

Voice Evaluation

Patient Sticker

Review of Systems: Have you recently experienced any of the following symptoms or problems? (Check all that apply)

General
- ☐ Weakness or tiredness
- ☐ Recent weight loss

Eyes
- ☐ Blurred vision
- ☐ Double vision

Ears, Nose, Mouth, and Throat
- ☐ Trouble hearing
- ☐ Tinnitus or ringing in the ears
- ☐ Ear pain
- ☐ Ear infection or drainage
- ☐ Dizziness, vertigo or unsteadiness
- ☐ Stuffy nose
- ☐ Sinus trouble
- ☐ Frequent nose bleeds
- ☐ Frequent sore throats
- ☐ Pain near teeth or mouth
- ☐ Hoarseness or voice change
- ☐ Difficulty with swallowing
- ☐ Lumps in the neck
- ☐ Pain in the neck

Cardiovascular
- ☐ Heart trouble
- ☐ Palpitations
- ☐ High blood pressure

Respiratory
- ☐ Cough
- ☐ Asthma or wheezing
- ☐ Shortness of breath

Hematologic
- ☐ Easy bruising or bleeding
- ☐ Anemia

Allergies
- ☐ Hay fever
- ☐ Dust or mold allergy
- ☐ Food sensitivity or intolerance
- ☐ Chemical or latex sensitivity

Gastrointestinal
- ☐ Heartburn or acid reflux
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Frequent use of antacids

Genitourinary
- ☐ Kidney problems

Musculoskeletal
- ☐ Joint pain or stiffness

Integumentary (Skin)
- ☐ Skin rashes

Neurological
- ☐ Headaches
- ☐ Numbness in the face, legs or arms
- ☐ Seizures
- ☐ Weakness in the arms or legs
- ☐ Blackouts or fainting
- ☐ Trouble speaking
- ☐ Confusion or memory loss

Psychiatric
- ☐ Nervousness or increased stress
- ☐ Sleep problems
- ☐ Excessive moodiness or worry

Endocrine
- ☐ Thyroid trouble
- ☐ Diabetes

Voice Evaluation

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Allergies

List any medications you are allergic to:

List any allergies we should know about:

List allergy treatments you take now. If you do not take any allergy treatments now, list ones you have taken before:

Is your allergy treatment effective? ☐ Yes ☐ No

Medications: List all medications you are taking, and for what reason.

Name of Medication	Reason

List any other medications, supplements, and vitamins you are taking:

Family History: Do you have a family history of any of the following? (Check all that apply)

- ☐ Autoimmune disease
- ☐ Heart disease
- ☐ Diabetes
- ☐ Other (Please list)
- ☐ Bleeding Disorder (Hemophilia, Von Willebrand's Disease)
- ☐ Reactions to anesthesia

Voice Evaluation

Patient Sticker

Smoking History

Cigarette, Cigar, Pipe smoking	☐ Never used	☐ Former user	☐ Current user
E-cigarette, Juul, Vape	☐ Never used	☐ Former user	☐ Current user
Chewing Tobacco	☐ Never used	☐ Former user	☐ Current user

At what age did you start smoking?

How often do you smoke?

How many packs a day do you smoke?

If you are a former smoker, at what age did you quit smoking?

Alcohol History

How many drinks a week do you have?

What kind of alcohol do you drink?
(Check all that apply) ☐ Beer ☐ Wine ☐ Liquor

Drug History (all answers will remain confidential)

Do you take part in recreational drug use?	☐ Yes	☐ No

What kinds of recreational drugs do you use now or have you used in the past?

How often do you use these drugs?

Reflux History

Do you have a history of acid reflux, heartburn or indigestion?	☐ Yes	☐ No
Has a doctor said you have Gastroesophageal Reflux Disease?	☐ Yes	☐ No

What are your symptoms?

How often do these symptoms happen?

List any medications that have been used to treat your reflux:

Do you use behavior changes to deal with your reflux symptoms?	☐ Yes	☐ No

Water and Caffeine Intake

How many 8 ounce glasses do you have a day?

Water _____ Caffeine (coffee, tea, soda) _____

Voice Evaluation

Patient Sticker

Vocal History

Are you a singer? If no, skip the following section. ☐ Yes ☐ No

Vocal Training Background
Name of school you went to for voice lessons:
Your voice part
Kind of accompaniment (such as piano, guitar…)
Type of amplification (speakers) used
Where do you perform:
Amount of times you practice each week

Voice Handicap Index (VHI-10)

Instructions: These are statements that many people have used to describe their voices and how it impacts their lives. On a scale of 0 to 4, circle the number that best applies to you.

0 is Never
1 is Almost never
2 is Sometimes
3 is Almost always
4 is 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 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 is wrong with your voice?”	0	1	2	3	4

Voice Evaluation

Patient Sticker

Dysphagia History (Problems with Swallowing)

Do you have a problem swallowing? ☐ Yes ☐ No

Describe your swallowing problem:

List any swallowing tests you have had, including when, where and the results:

Eating Assessment Tool (EAT-10)

Instructions: How much are these a problem for you? On a scale of 0 to 4, circle the number that best applies to you.

0 is No problem
1 is Mild problem
2 is Mild to moderate problem
3 is Moderate problem
4 is Severe problem

1. My swallowing problem has caused me to lose weight.	0	1	2	3	4
2. My swallowing problem gets in the way of my being able to go out for meals.	0	1	2	3	4
3. Swallowing liquids takes more effort.	0	1	2	3	4
4. Swallowing solids takes more effort.	0	1	2	3	4
5. Swallowing pills takes more effort.	0	1	2	3	4
6. Swallowing is painful.	0	1	2	3	4
7. The pleasure of eating is affected by my swallowing.	0	1	2	3	4
8. When I swallow, food sticks to my throat.	0	1	2	3	4
9. I cough when I eat.	0	1	2	3	4
10. Swallowing is stressful.	0	1	2	3	4

Is there any other information you would like to share?

Your Printed Name: _____

Your Signature: _____ Date: _____

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