Adult Voice Case History

Please fill out this form as completely as possible and send these forms to our office TWO DAYS prior to your evaluation. If you need more space, attach another page. We look forward to meeting you.

I. GENERAL INFORMATION Date:_____

Patient Name:_____ Date of Birth:_____

Patient Email Address:_____

Primary Care Physician:_____ Phone:_____

Address:_____ Fax:_____

_____

Referring Physician (if different):_____ Phone:_____

Address:_____ Fax:_____

_____

Occupation(s):_____Part time/full time/unemployed/retired/disabled?

_____Part time/full time/unemployed/retired/disabled?

What is your native language?_____

Are you a singer? If so, how often do you sing?_____

II. HISTORY OF THE PROBLEM

1. Briefly describe your reasons for seeking an evaluation?_____

   _____
2. What symptoms are you currently experiencing?_____

   _____
3. When did these symptoms begin?_____

   _____

4. Have your symptoms changed since you first noticed them?_____

   _____

5. Were there any events or conditions with which you can associate the onset of your symptoms?_____

   _____

6. Are there any situations in which your voice is better or seems to improve?_____

   _____

7. Have you had the same or similar problems in the past?_____

   _____

8. Have you been to any specialists in relation to these symptoms? If so, whom have you seen?_____

   _____

9. Have you ever had any surgery or other medical procedures to the larynx or the respiratory system?_____

10. Is your voice worse at certain times of the day?

    ____ no variation
    ____ upon wakening
    ____ early in the day
    ____ middle of the day
    ____ end of the day
    ____ lack of sleep
    ____ during work hours
    ____ other (specify)_____

11. List any other referrals or recommendations that have been made:_____

    _____

12. Do you have a family history of speech, language, voice, cognition or hearing problems? (Please specify)_____

    _____

13. Have you ever received voice therapy in the past?

    When_____

    Duration _____

    Therapist Name_____

    Please give a brief description of what you did in therapy?_____

    _____

14. What vocal symptoms are you experiencing?

    Please check all that apply to you:

___ no voice at all	___ unsteady/shaky voice	___ tickling sensation in throat
___ whisper only	___ voice breaks	___ frequent dry throat
___ weak cry	___ trouble speaking loudly	___ frequent throat clear
___ breathy-weak tone	___ trouble speaking softly	___ pain in throat/ irritation
___ raspy voice quality	___ effortful voicing/strain	___ lump in throat sensation
___ scratchy voice quality	___ voice fatigues easily	___ frequent coughing
___ voice seems high	___ air escapes through nose	___ throat clicks sensation
___ voice seems low	___ stuffed nose quality	___ other (specify)_____

15. Besides voice therapy, is there anything that you are doing that improves your voice?____

    _____

16. Do you participate in fewer social activities since the current difficulties began? For example, are you less talkative?_____

    _____

17. Has the voice problem interfered with any work, school or social activities?_____

    _____

18. How do people react to your voice problem?_____

    _____

19. Please check any irritants you feel you have any respiratory or voice reactions to?

___ second-hand smoke	___ sustained loud noise
___ pollution	___ dry environments
___ dust/allergens	___ chemicals
___ frequent loud noise	___ other (please specify)_____

20. How many servings of caffeine do you have per day or week?_____
21. How much water do you drink daily?_____
22. Please list any allergies you have (medications, environmental)?_____

    _____

III. SWALLOWING

1. Do you cough or choke while eating or just after a meal? If yes, please describe the nature and frequency of the problem?_____

   _____

2. Does it take multiple swallows to get food down? _____
3. Have you ever had pneumonia? If yes please list dates: _____

4. How long does it take to finish a meal? _____

IV. MEDICAL HISTORY

1. Please check any of the conditions you currently have or had in the past:

___ High blood pressure
___ Low blood pressure
___ Heart disease
___ Stroke
___ Heart attack
___ Tuberculosis
___ Asthma
___ COPD
___ Kidney Disease
___ Urinary problems
___ Head injury
___ Whiplash
___ Injury to neck or chest
___ Sinusitis
___ Depression
___ Reflux
___ Cleft Palate
___ Frequent upset stomach
___ Confusion
___ Memory change
___ Frequent headaches
___ Tremor
___ Insomnia
___ Myasthenia Gravis
___ Parkinson's Disease
___ Multiple Sclerosis
___ ALS (Lou Gherig's Disease)
___ Seizures
___ Meningitis
___ Lupus
___ Diabetes
___ Endocrine Disorder
___ Thyroid Disease
___ Hypoglycemia
___ Arthritis
___ AIDS or immunologic disorder
___ Cancer
___ Syphilis
___ Hiatal Hernia
___ Hearing loss
___ Night coughing that interrupts sleep
___ Heartburn
___ Pain in body, where?_____
___ Nasal regurgitation
___ Shortness of breath
___ Anxiety
___ Other (Please specify)_____

2. Please indicate any medical procedures you have had:

___ Tonsillectomy
___ Adenoidectomy
___ Appendectomy
___ Oral surgery
___ Heart surgery
___ Other (Specify)_____
___ Tracheotomy
___ Lung Surgery
___ Chemotherapy (When?)_____
___ Thyroid surgery
___ Radiation (Specify)_____

VOICE HANDICAP INDEX

Name: _____ Date: _____

These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0-never 1-almost never 2-sometimes 3-almost always 4-always

Part I-F

My voice makes it difficult for people to hear me.	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My family has difficulty hearing me when I call them throughout the house.	0	1	2	3	4
I use the phone less often than I would like to.	0	1	2	3	4
I tend to avoid groups of people because of my voice.	0	1	2	3	4
I speak with friends, neighbors, or relatives less often because of my voice.	0	1	2	3	4
People ask me to repeat myself when speaking face-to-face.	0	1	2	3	4
My voice difficulties restrict my personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4

SUBTOTAL _____

Part II-P

I run out of air when I talk.	0	1	2	3	4
The sound of my voice varies throughout the day.	0	1	2	3	4
People ask, "What's wrong with your voice?"	0	1	2	3	4
My voice sounds creaky and dry.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
I try to change my voice to sound different.	0	1	2	3	4
I use a great deal of effort to speak.	0	1	2	3	4
My voice is worse in the evening.	0	1	2	3	4
My voice "gives out" on me in the middle of speaking.	0	1	2	3	4

SUBTOTAL _____

Part III-E

I am tense when talking to others because of my voice.	0	1	2	3	4
People seem irritated with my voice.	0	1	2	3	4
I find other people don't understand my voice problem.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
I am less outgoing because of my voice problem.	0	1	2	3	4
My voice makes me feels handicapped.	0	1	2	3	4
I feel annoyed when people ask me to repeat.	0	1	2	3	4
I feel embarrassed when people ask me to repeat.	0	1	2	3	4
My voice makes me feel incompetent.	0	1	2	3	4
I am ashamed of my voice problem.	0	1	2	3	4

SUBTOTAL _____

TOTAL _____

The Voice Handicap Index (VHI): Development and Validation
Barbara H. Jacobson, Alex Johnson, Cynthia Grywalski, Alice Silbergleit, Gary Jaconsen, Michael S. Benninger

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