Stony Brook Medicine

SPEECH-LANGUAGE PATHOLOGY
VOICE CASE HISTORY FORM

Name: _____
Date of Birth: _____

ENT Physician: _____ **Last exam and findings:** _____

Past Medical History

Anxiety	□YES	□NO	Laryngitis	□YES	□NO
ADHD	□YES	□NO	Learning Disability	□YES	□NO
ADD	□YES	□NO	Thyroid Disease	□YES	□NO
Asthma	□YES	□NO	Tracheostomy tube	□YES	□NO
Allergies	□YES	□NO	Pneumonia	□YES	□NO
Gastric Reflux	□YES	□NO	Radiation Therapy	□YES	□NO
Bronchitis	□YES	□NO	Swallowing Problems	□YES	□NO
Cardiac Disease	□YES	□NO	Shortness of breath	□YES	□NO
Chemotherapy	□YES	□NO	Seizures	□YES	□NO
COPD	□YES	□NO	Sleep Apnea	□YES	□NO
Diabetes	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Dementia	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Depression	□YES	□NO	Voice Impairment	□YES	□NO
Hearing Loss	□YES	□NO	Thyroid Disease	□YES	□NO
High Blood Pressure	□YES	□NO	Head/Neurological Injury	□YES	□NO

Cancer □ No □ Yes – if so, describe: _____
Please list any other conditions or illnesses for which you have been treated or take medication for:
_____
List medications or attach list:

Please check any of the following specialists seen in past: □ Physical or Occupational Therapist
□ Ear Nose and Throat Specialist □ Eye Specialist □ Neurologist □ Psychiatrist □ Psychologist □ Pulmonologist
□ Cardiologist □ Neuropsychologist □ Speech/Language Pathologist □ Audiologist (Hearing Test)

Family and Social History: Please check all that apply
□ Working – if so, occupation: _____ □ Student □ Live alone □ Live with _____
Tobacco use: □ No □ Current □ Quit - discontinued date: _____ # of years smoked: _____ packs/day: _____
Alcohol use: □ No □ Yes – if so, _____drinks/week
□ Recreational drug use – if yes, what type/frequency: _____

Description of vocal quality: _____
Check all that apply: □ rough □ raspy □ strained □ hoarse □ nasal □ breathy □ too soft □ too loud
□ loss of voice □ voice breaks □ pitch too high □ pitch too low □ voice becomes tired □ other: _____
_____
Onset/duration of vocal quality change: (Date) _____ □ Gradual □ Sudden
Did it follow any illness/family problem/traumatic event? □ NO □ YES
Please describe: _____
Has it changed over time? _____
Is the problem: □ Consistent □ Intermittent
When is your voice best? _____
When is your voice worst? _____

 Reviewed by SBUH SLP _____
Initials

Name: _____
Date of Birth: _____

Has the vocal quality change affected your daily life? □ NO □ YES – if so, how: _____
_____

Vocal Hygiene: Please estimate the number of times each day the following occur?

Cups of water consumed: _____
Cups of caffeinated beverages: _____
Other beverages consumed: _____
Cough/throat clear: _____
Yell/Scream: _____
Speak above noise: _____

Do you exercise? □ NO □ YES **What type/How frequently?** _____
How many hours of sleep do you get per night? _____
How is your nutrition? □ Good □ Fair □ Poor

Do you experience any of the following? (Check all that apply)

□ Poor morning voice quality
□ Frequent throat clearing
□ Increased phlegm in the throat
□ Tastes repeating after meals
□ Increased throat/mouth dryness
□ Frequent burping
□ Feeling of throat tightness
□ Throat soreness or burning sensation not related to illness
□ Coughing episodes not related to illness/swallowing
□ Heartburn (If checked, how many times per week? ____)
□ Feeling of a lump in the throat when swallowing
□ Bad taste in the mouth (please circle: sour, acidic, metallic)
□ Unpredictable/variable voice quality during the day
□ Increased coughing when lying down

Do you often need to repeat yourself to be understood? □ Yes □ No
Do you have difficulty: □ Projecting your voice □ Being understood by listeners □ Speaking at length
□ Speaking on the telephone □ Participating in group conversations □ Communicating in noisy environments
Are you exposed to an environment with: □ Dust □ Smoke □ Chemicals
Do you have any allergic response to pets in your home? □ NO □ YES
Are there any household pets? □ NO □ YES – if so, please list: _____

Have you received previous voice therapy? □ NO □ YES - **When? (Date)**_____
Please provide the name, phone number and location where you received the therapy:
_____

Have you had any professional voice training? □ NO □ YES – if yes, with whom and for how many years?
_____

Do you sing? □ NO □ YES – if yes: □ Recreational (for fun) □ Amateur performance □ Professional performance
□ Style of music: _____ □ Choral □ Solo □ Band
Hours/week practice: _____ Hours/week performance: _____
What is your range? □ Soprano □ Mezzo □ Alto □ Tenor □ Baritone □ Bass
What is your goal for changing your voice? _____

Please write down any additional information you feel will help us understand your voice problem:
_____
_____
_____

Speech Pathologist's Notes: _____
_____

Name: _____
Date of Birth: _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

☐ **Reviewed by SBUH SLP_____ _____**
Name/ ID number **date/time**

SLP Notes: