The Blaine Block Institute for Voice Analysis and Rehabilitation

Please provide the following information as accurately and completely as possible. This information is very important to your care at the voice institute.

Patient name: _____ Today's date: _____
Date of birth: _____Age: _____ Referring physician: _____
Occupation: _____ Family physician: _____
Home phone: _____ Date of next appointment with referring physician:
Work phone: _____ _____
If you would like to receive our email newsletter, please provide your email address:
_____

What is your chief complaint? Please Circle All that Apply →

Hoarseness Chronic Laryngitis Change in voice Sore throat

Difficulty swallowing Feeling of something in your throat

Other (please describe)_____

Have you ever received voice therapy in the past? Yes No

Medication (Please list any medication you are taking – include prescription, over-the-counter, herbal.)
* If you provide a list, we will make a copy

Medication allergies and Environmental allergies (e.g. hay fever, pollen, mold, dust, foods, etc.) (Indicate if you have had an allergy test and the results.)

Are you a professional (singer/actor/TV/radio) or semi-professional (clergy/educator/choir) voice user? Yes/no
Define:_____

Indicate whether or not you have ever had any of the following:

Anxiety Disorder	Yes No	Heartburn	Yes No	Throat clearing	Yes No
Arthritis	Yes No	Heart Disease	Yes No	Throat pain	Yes No
Asthma	Yes No	Hiatal hernia	Yes No	Thyroid problems	Yes No
Breathing problems	Yes No	High blood pressure	Yes No	TMJ disorder	Yes No
Change in your voice	Yes No	Lump in throat sensation	Yes No	Tremor	Yes No
Change in weight (Gain/Loss)	Yes No	Lung Disease	Yes No	Ulcers	Yes No
Choking	Yes No	Muscle weakness	Yes No	Wheezing	Yes No
Circulation problems	Yes No	Neck or back surgery	Yes No	Cancer	Yes No
Chronic Cough	Yes No	Neck masses or lumps	Yes No	Type_____	
Depression	Yes No	Neurological problems	Yes No		
Diabetes	Yes No	Post-nasal drainage	Yes No		
Digestive/stomach problems	Yes No	Psychiatric Disorder	Yes No		
Ear pain	Yes No	Sinus problems	Yes No		
Elevated cholesterol	Yes No	Sleep Disorder	Yes No		
Headaches (frequent)	Yes No	Swallowing problems	Yes No		
Hearing loss	Yes No	Swollen glands	Yes No	**PLEASE TURN OVER**	

Do you currently smoke? *Yes No* (circle)

Cigarettes / cigar / pipe / other_____(circle) How many per day/week?_____ How long? _____

Are you a past smoker? *Yes No* How many per day/week?_____ Quit when & smoked how long?_____
Recreational drug use? _____

Alcohol intake? (indicate type and amount)**:** _____
Daily intake of: Water_____ Juices_____ Milk _____ Coffee_____ Tea_____ Soda_____ Chocolate_____
(indicate amounts/glasses per day)

Please read the following questions and circle the number from 1-5 that best describes your symptoms:

0 = no problem 1 = mild 2 = mild to moderate 3 = moderate 4 = moderate to severe 5 = severe

Within the past month, how did the following problems affect you?

1. Hoarseness or a problem with your voice (chronic or intermittent, vocal fatigue or voice breaks)	0	1	2	3	4	5
2. Clearing your throat (often excessive)	0	1	2	3	4	5
3. Excess throat mucus or post nasal drip	0	1	2	3	4	5
4. Difficulty swallowing food, liquids or pills (dysphagia)	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 (wheezing, and/or airway obstruction)	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 (regurgitation)	0	1	2	3	4	5

Within the last month, how have the following problems affected you?

0= No problem 5=Severe problem

1. Speaking took extra effort	0	1	2	3	4	5
2. Throat Discomfort/Pain	0	1	2	3	4	5
3. Vocal fatigue	0	1	2	3	4	5
4. Voice sounds different/cracks	0	1	2	3	4	5