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

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers

Name	Relationship to patient	Address	Phone	Fax
Name	Relationship to patient	Address	Phone	Fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.
Signature of □Patient □Parent/Guardian _____ Date: _____
Printed name of Parent/Guardian: _____

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

SLP Notes: