Laryngology and Voice Disorders Center
University Hospitals Case Medical Center
NEW PATIENT REVIEW OF SYSTEMS FORM

*Date*____________ ☐ *Male* ☐ *Female*

*Name*______________________________

*Address*______________________________

____
City State Zip

*Home Phone*______________________________

*Referred by*______________________________

*Marital Status*______________________________

*Occupation*______________________________

*Age*____________ *Date of Birth*____________

*Work or cell Phone*______________________________

*Primary Care and other physicians*______________________________

____

Symptoms: *Please mark (x) in the available blanks if any of the following apply to you* **Now** *or in the* **Past:**

Now	Past	***Head, Eyes, Ears, Nose, Throat***
☐	☐	Noise exposure
☐	☐	Head injury or concussion
☐	☐	Draining or painful ears
☐	☐	Hearing loss
☐	☐	Ringing in ears
☐	☐	Dizziness or loss of balance
☐	☐	Chronic facial pain or headaches
☐	☐	Chronic nasal congestion or drainage
☐	☐	Frequent nose bleeds
☐	☐	Difficulty swallowing
☐	☐	Hoarseness
☐	☐	Throat pain
☐	☐	Jaw pain
☐	☐	Chronic cough
☐	☐	Tooth pain/Loose teeth/Bite problems
☐	☐	Snoring/Sleep Apnea
☐	☐	Double vision/Eye pain/Change in vision

General

☐	☐	Unexplained fever/Night sweats
☐	☐	Unexplained weight loss or gain
☐	☐	Joint pains and swelling

Lungs

☐	☐	Coughing up blood
☐	☐	Persistent wheezing/Asthma
☐	☐	Shortness of breath
☐	☐	Abnormal chest x-ray

Heart - Circulation

☐	☐	Chest pain
☐	☐	Heart palpitation
☐	☐	Leg vein trouble/Leg pain when walking
☐	☐	Ankle swelling

Stomach - Intestinal

☐	☐	Heartburn or Regurgitation or Indigestion
☐	☐	Frequent or severe stomach pain
☐	☐	Frequent or severe vomiting
☐	☐	Vomiting blood

Now	Past	***Urinary***
☐	☐	Frequent urination/Trouble holding urine
☐	☐	Trouble starting urine
☐	☐	Urinate more than two times a night

Nervous System

☐	☐	Fainting spells (blackouts)
☐	☐	Convulsions (seizures, fits, epilepsy)
☐	☐	Tremor (shaking, trembling)
☐	☐	Paralysis (or weakness of any body part)
☐	☐	Numbness (body parts "go to sleep")

Females

☐	☐	Pregnant

Date of last period_______ /______ /______

Number of pregnancies _________

Live Births _________ Abortions _________

Endocrine System

☐	☐	Dry skin, cold intolerance
☐	☐	Thirst
☐	☐	Appetite change

Allergy / Immune System

☐	☐	Hives or chronic itching
☐	☐	Previous allergy workup
☐	☐	Hay Fever

Heme / Lymph System

☐	☐	Easy bruising
☐	☐	Bleeding problems
☐	☐	Fatigue
☐	☐	Enlarged glands

Past Medical History: *List type of illness, place, & date:*

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Past Surgeries: *List type of operation, place & date:*

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Health History: *Have you had any of the following?*

Yes	*No*	
☐	☐	Cancer (type) ______________
☐	☐	Heart murmur
☐	☐	High Blood pressure
☐	☐	Liver disease, yellow jaundice, hepatitis
☐	☐	Mental troubles or nervous breakdown
☐	☐	Pneumonia
☐	☐	Artificial joints or heart valves
☐	☐	Do you take antibiotics when you go to the dentist?
☐	☐	Serious injury/accident
☐	☐	Diabetes
☐	☐	Tuberculosis (TB)
☐	☐	Uncontrolled bleeding
☐	☐	Kidney disease
☐	☐	HIV/AIDS
☐	☐	Difficulty with anesthetic
☐	☐	Heart attack
☐	☐	Thyroid disease
☐	☐	Abnormal EKG
☐	☐	Stroke
☐	☐	Facial fracture or jaw fracture
☐	☐	Have you used aspirin within the last 2 weeks?

How much? ______________

Drug Allergies: ______________

____

____

Medications: *(list dose and frequency)? Include non-medicines, herbal supplements and/or vitamins. Attach separate sheet if needed.*

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Social History:

Smoking: ☐ cigarettes ☐ pipe ☐ cigars
☐ none ☐ quit
Number of years:________ Daily amount_________

Alcohol: ☐ beer ☐ wine ☐ other liquors
☐ none ☐ quit
Amount per week:______________

Do you use marijuana? ☐ Yes ☐ No

Do you use other recreational drugs? ☐ Yes ☐

Family Member	Age	**If Living** Present Health			**If Not Living**	
		Good	Fair	Poor	Age at Death	Cause of Death
Mother						
Father						
Brothers/ Sisters						
Children						

Physician Signature: **Date:** **Name:**

Laryngology and Voice Disorders Center
University Hospitals Case Medical Center
NEW PATIENT REVIEW OF SYSTEMS FORM

Patient label here

Patient Sticker/Imprir

Patient Name:______________________

MR#:______________________

DOB:______________________

Laryngology and Voice Disorders Center
University Hospitals Case Medical Center
Voice History Form

1. Describe the problem you're having with your voice:
   ____
   ____
2. When was it first noticed?______________________
3. Who noticed the problem?______________________
4. Did the problem develop slowly or suddenly? ______________________
5. Do you recall doing anything unusual about the time the problem was first noticed (illness; accident; surgery)?
   Yes ☐ No ☐ If yes, explain ______________________
6. Does your voice problem vary during the day? ☐ Yes ☐ No
   The best times are______________________
   The worst times are ______________________
7. Has the problem become better or worse recently? ______________________
8. What do you think caused your voice problem? ______________________
9. How typical is your voice today? (0 is best voice or no problem – 10 is worst)
   ____
10. How do you use your voice during the day? ______________________
11. What is your environment like?
    home: ☐background noise ☐need for loud speech
    ☐excessive talking ☐other:______________
    work: ☐background noise ☐need for loud speech
    ☐excessive talking ☐other: ______________
12. Any leisure activities that involve your voice (e.g. singing, coaching, spectator sports)?______________
13. Substances that can affect your voice:
    a. Cigarettes ☐Yes ☐No How many daily?________ Years__________Quit Date______
    b. Drugs ☐Yes ☐No Type__________ times daily?________ Years___Quit Date______
    c. Alcohol ☐Yes ☐No How much daily?________ Years__________ Quit Date______
    d. Coffee / Tea ☐Yes ☐No How much daily?________ Years__________
    e. How many 6 – 8 oz glasses of non-caffeinated beverages do you drink during the day? __________
14. Do you have any problems with swallowing? ☐ Yes ☐ No
    If yes, please circle: aspiration/choking nasal regurgitation food sticking other: __________
15. Have you had previous voice treatment? ☐Yes ☐No
    If yes, what was the nature of the treatment? ______________________
16. Is there a history of speech or voice problems in your family? ☐ Yes ☐ No If yes, explain:
    ____
17. Do you have heartburn, indigestion, reflux? ☐Yes ☐No If yes, how often? ______________
18. Are you a singer? ☐Yes ☐No If yes, describe your range, numbers of hours a week of performance/practice and current difficulties______________________
    ____
    ____

**********************PLEASE COMPLETE THE SECOND PAGE OF THIS FORM

Patient Sticker/Imprir

Patient Name:______________________
MR#:______________________
DOB:______________________

Voice Handicap Index (VHI)

(Jacobson et al., 1997)

Instructions: 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

F1.	My voice makes it difficult for people to hear me.	0	1	2	3	4
P2.	I run out of air when I talk.	0	1	2	3	4
F3.	People have difficulty understanding me in a noisy room.	0	1	2	3	4
F4.	The sound of my voice varies throughout the day.	0	1	2	3	4
F5.	My family has difficulty hearing me when I call them throughout the house.	0	1	2	3	4
F6.	I use the phone less often than I would like.	0	1	2	3	4
E7	I'm tense when talking with others because of my voice.	0	1	2	3	4
F8.	I tend to avoid groups of people because of my voice.	0	1	2	3	4
E9.	People seem irritated with my voice.	0	1	2	3	4
P10.	People ask. "What's wrong with your voice?"	0	1	2	3	4
F11.	I speak with friends, neighbors, or relatives less often because of my voice.	0	1	2	3	4
F12.	People ask me to repeat myself when speaking face-to-face.	0	1	2	3	4
P13.	My voice sounds creaky and dry.	0	1	2	3	4
P14.	I feel as though I have to strain to produce voice.	0	1	2	3	4
E15.	I find other people don't understand my voice problem.	0	1	2	3	4
F16.	My voice difficulties restrict my personal and social life.	0	1	2	3	4
P17.	The clarity of my voice is unpredictable.	0	1	2	3	4
P18.	I try to change my voice to sound different.	0	1	2	3	4
F19.	I feel left out of conversations because of my voice.	0	1	2	3	4
P20.	I use a great deal of effort to speak.	0	1	2	3	4
P21.	My voice is worse in the evening.	0	1	2	3	4
F22.	My voice problem causes me to lose income.	0	1	2	3	4
E23.	My voice problem upsets me.	0	1	2	3	4
E24.	I am less outgoing because of my voice problem.	0	1	2	3	4
E25.	My voice makes me feel handicapped.	0	1	2	3	4
P26.	My voice 'gives out' on me in the middle of speaking.	0	1	2	3	4
E27.	I feel annoyed when people ask me to repeat.	0	1	2	3	4
E28.	I feel embarrassed when people ask me to repeat.	0	1	2	3	4
E29.	My voice makes me feel incompetent.	0	1	2	3	4
E30.	I am ashamed of my voice problem.	0	1	2	3	4

Total Score:______

X

SIGNATURE OF PERSON COMPLETING FORM | PRINT NAME | DATE

Rev. 6/8/2007