SAN FRANCISCO

VOICE & SWALLOWING

KATHERINE C. YUNG, MD FACS

Follow up Visit

Patient Name: ____________________________________ **DOB:** _____________________

VOICE HANDICAP INDEX – 10 (VHI-10)

Below are statements describing your voice and the impact it has on your life. Circle the response that indicates how frequently you have a similar experience.

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

Statement						
1. My voice makes it difficult for people to hear me.		0	1	2	3	4
2. People have difficulty understanding me in a noisy room		0	1	2	3	4
3. My voice difficulties restrict my personal and social life.		0	1	2	3	4
4. I feel left out of conversations because of my voice		0	1	2	3	4
5. My voice problem causes me to lose income		0	1	2	3	4
6. I feel that I have to strain to speak.		0	1	2	3	4
7. The clarity of my voice is unpredictable.		0	1	2	3	4
8. My voice problem upsets me.		0	1	2	3	4
9. My voice makes me feel handicapped		0	1	2	3	4
10. People ask, “What’s wrong with your voice?”		0	1	2	3	4

Please add up your total = _________________

REFLUX SYMPTOM INDEX (RSI)

Within the last month, how did the following problems affect you? Circle the appropriate response. 0 = no problem, 5 = severe problem

Problem							
1. Hoarseness or a problem with your voice		0	1	2	3	4	5
2. Clearing your throat		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		0	1	2	3	4	5
5. Coughing after you eat or after lying down		0	1	2	3	4	5
6. Breathing difficulties or choking episodes		0	1	2	3	4	5
7. Troublesome or annoying cough		0	1	2	3	4	5
8. Sensation 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		0	1	2	3	4	5

Please add up your total =______________________

Signature:____ Date:______________________