SAN FRANCISCO

# VOICE & SWALLOWING

KATHERINE C. YUNG, MD FACS

## ADULT HEALTH HISTORY FORM

NAME:_____ DOB:_____

PREFERRED NAME (If other): _____ Visit Date: _____

Who referred you to our office?_____Primary care physician:_____

What is the **Main Reason** for your visit today?_____

_____

How long has this problem existed?_____

**ALLERGIES/SENSITIVITIES TO MEDICATIONS**: (Please describe reaction) □ *NONE*

| | |
|---|---|
| | |
| | |

**CURRENT MEDICATIONS WITH DOSAGE:** (Please include over the counter and herbal supplements) □ *NONE*

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Pharmacy Preference:** _____

**PAST MEDICAL HISTORY:** □ *NONE*

| | | | | | |
|---|---|---|---|---|---|
| Allergies | Y | N | Heart disease | Y | N |
| Anemia | Y | N | Hepatitis | Y | N |
| Anxiety | Y | N | High Blood Pressure | Y | N |
| Asthma | Y | N | High Cholesterol | Y | N |
| Bleeding disorder | Y | N | HIV/AIDS | Y | N |
| Cancer | Y | N | Kidney disease | Y | N |
| Chronic bronchitis | Y | N | Liver disease | Y | N |
| Depression | Y | N | Lung disease/Pneumonia | Y | N |
| Diabetes mellitus | Y | N | Psychiatric Disorder | Y | N |
| GERD (Reflux) | Y | N | Salivary Duct Stone | Y | N |
| Hearing loss | Y | N | Seizures | Y | N |
| Heart attack | Y | N | Sinus disorder | Y | N |

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| | | | | | |
|---|---|---|---|---|---|
| Sleep Apnea | Y | N | Thyroid disease | Y | N |
| Stomach ulcers | Y | N | Tuberculosis | Y | N |
| Stroke | Y | N | | | |

**OTHER MEDICAL PROBLEMS:** _____

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**PAST SURGICAL HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| Adenoidectomy | Y | N | Facial cosmetic surgery | Y | N |
| Appendectomy | Y | N | Nasal surgery | Y | N |
| Bronchoscopy | Y | N | Neck surgery | Y | N |
| Cardiac surgery | Y | N | Orthopedic Surgery | Y | N |
| Dental Surgery | Y | N | Salivary gland surgery | Y | N |
| Ear Surgery | Y | N | Sinus surgery | Y | N |
| Ear tubes | Y | N | Throat surgery | Y | N |
| Esophagus surgery | Y | N | Thyroid Surgery | Y | N |
| Eye surgery | Y | N | Tonsillectomy | Y | N |

**OTHER SURGICAL HISTORY:** _____

_____

**FAMILY HISTORY**: *(M=mother; F=father; S=sister; B=brother; C= child)*

| | | M | F | S | B | C |
|---|---|---|---|---|---|---|
| Allergies | | | | | | |
| Anesthesia problems | | | | | | |
| Asthma | | | | | | |
| Bleeding disorder | | | | | | |
| Cancer (type: ) | | | | | | |
| Diabetes | | | | | | |
| Genetic disease | | | | | | |

| | M | F | S | B | C |
|---|---|---|---|---|---|
| | | | | | |
| Heart disease | | | | | |
| High blood pressure | | | | | |
| Kidney disease | | | | | |
| Psychiatric illness | | | | | |
| Stroke | | | | | |
| Sudden death | | | | | |

**SOCIAL HISTORY:**

Cigarette use: □ Current Smoker □ Former Smoker (Quit Date_____) □ Never Smoked

If current or former smoker: # cigarettes/day_____ for _____ years

Smokeless Tobacco: □ Current User □ Former User (Quit Date _____) □ Never Used

Alcohol (drinks/week)_____ Recreational drugs? Yes_____ No

Occupation_____

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**FOR FEMALE PATIENTS:** Are you pregnant, OR trying to get pregnant? Yes No

**REVIEW OF SYSTEMS**: Indicate symptoms you are *currently* experiencing

| | | |
|---|---|---|
| □ Appetite change | □ Difficulty breathing | □ Voice Change |
| □ Fatigue | □ Wheezing | □ Skin rash |
| □ Fever/chills/night sweats | □ Nausea/vomiting | □ Mental status changes |
| □ Unintended weight loss | □ Abdominal pain | □ Weakness |
| □ Vision changes | □ Change in bowel habits | □ Changes in sensation |
| □ Eye pain | □ Frequent urination | □ Headache/migraine |
| □ Chest pain | □ Urgency/incontinence | □ Heat/cold intolerance |
| □ Shortness of breath | □ Pain with urination | □ Bleed easily/Bruise easily |
| □ Swelling in hands/feet | □ Joint pain/swelling | |

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## 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

| | | | | | | |
|---|---|---|---|---|---|---|
| 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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 =_____**

**Form completed** by (print):_____

Signature:_____ Date:_____

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