SAN FRANCISCO
VOICE & SWALLOWING
KATHERINE C. YUNG, MD FACS

PEDIATRIC HEALTH HISTORY FORM

NAME:_____ DOB:_____WEIGHT: _____

PREFERRED NAME (if other):_____Visit date:_____

Who referred you to our office?_____Pediatrician:_____

What is the **Main Reason** for your child's 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*

PAST MEDICAL HISTORY: □ *NONE*

Allergies	Y	N	Kidney disease	Y	N
Anemia	Y	N	Language delay	Y	N
Asthma	Y	N	Liver disease	Y	N
Bleeding disorder	Y	N	Lung disease/Pneumonia	Y	N
Cancer	Y	N	Premature Birth	Y	N
Depression	Y	N	Psychiatric Treatment	Y	N
Diabetes mellitus	Y	N	Seizures	Y	N
Ear infection	Y	N	Sinus disorder	Y	N
GERD (Reflux)	Y	N	Sleep Apnea	Y	N
Hearing loss	Y	N	Speech delay	Y	N
Heart disease	Y	N	Stomach ulcers	Y	N
Hepatitis	Y	N	Thyroid disease	Y	N
HIV/AIDS	Y	N			

OTHER MEDICAL PROBLEMS:_____

_____

PAST SURGICAL HISTORY:_____

_____

450 SUTTER STREET • SUITE 939 • SAN FRANCISCO, CA 94108

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

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

	M	F	S	B
Hearing loss				
Heart disease				
High blood pressure				
Kidney disease				
Psychiatric illness				
Stroke				
Sudden death				

BIRTH HISTORY:
Birth Weight: _____lbs. _____oz. How many weeks gestation?_____
Pregnancy complications (list any)_____
NICU stay? Y N Newborn hearing screen results: Pass Fail Unknown

IMMUNIZATIONS: Up to date or delayed? _____

SOCIAL HISTORY: Circle all that apply
Who has legal custody of the child? Mother Father Other
Child lives with: Mother Father Other family Foster family
Parents are: Married Not married Partnered Separated Divorced
Does your child attend: Daycare Preschool Grade in school?_____
Number of siblings:_____

REVIEW OF SYSTEMS: Indicate symptoms that your child is *currently* experiencing

□ Appetite change
□ Low energy
□ Fever/chills/night sweats
□ Weight loss
□ Vision changes
□ Difficulty breathing
□ Wheezing
□ Nausea/vomiting
□ Abdominal pain
□ Change in bowel habits
□ Pain with urination
□ Joint pain/swelling
□ Skin rash
□ Mental status changes
□ Weakness
□ Headache
□ Anxiety
□ Bleed easily
□ Bruise Easily

Parent/Guardian Signature:_____

Relationship to Patient: _____

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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: _____

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