BaylorScott&White

THE VOICE CENTER

DALLAS

A member of HealthTexas Provider Network

New Patient ILS History

Patient Name:______________________________ **Date:**____________

1. What is the reason for your visit today? ____________________________

2. Did symptoms start: (Circle one) suddenly / gradually

3. When did your symptoms start? ____________________________

4. Was there anything going on prior to or during the time your symptoms began (e.g. cold, sinus infection, stress, increased voice use, acid reflux event, other illness)? If so, please describe below?

   ____

Please mark all of the following that apply on the questions below:

5. How would you describe your symptoms?
   - mild
   - moderate
   - severe

6. Do you have any of the following symptoms?
   - burning sensation in throat
   - chronic cough
   - difficulty breathing
   - difficulty swallowing
   - excessive throat clearing
   - excessive throat mucus
   - fullness in throat
   - heartburn/regurgitation
   - hoarseness
   - noisy breathing
   - sensation of something stuck in throat
   - throat pain

7. Do you have a cough? Circle one: **YES** / **NO**

   If no, please skip to question 16.

8. Do you cough up mucus when coughing? Circle one: **YES** / **NO**

9. If yes, do you cough up mucus
   - on the first cough
   - at the end of coughing

10. Describe your cough:

- occurs in short bursts (1-2 small coughs) throughout day
- coughing episodes (multiple coughs in a row that are difficult to stop)
- both

11. How often do you have coughing episodes and how long do they last:
    - daily
    - multiple times per day
    - weekly
    - multiple times per week
    - monthly
    - multiple times per month
    - lasting less than 1 minute
    - lasting 1-3 minutes
    - lasting longer than 5 minutes

12. Are your symptoms:
    - improving
    - stable
    - worsening

13. What triggers your cough?
    - airborne irritants (e.g. bleach, cleaners, perfumes, potpourri, candles, gasoline, etc.)
    - extreme temperature changes (e.g. going from air-conditioned building to hot car)
    - humidity
    - laughter
    - lying down
    - physical exercise/exertion
    - talking

14. Is there anything that helps you reduce or stop your cough?
    - sipping water
    - slowing breathing
    - stopping activity
    - sucking on lozenges
    - swallowing
    - other ____

15. Does coughing ever lead to any of the following?
    - dizziness
    - fainting
    - hoarseness
    - incontinence
    - lightheadedness
    - shortness of breath (SOB)

16. Have you been diagnosed with any respiratory illnesses?
    - asthma confirmed with methacholine challenge
    - asthma diagnosed as adult
    - asthma diagnosed as child
    - chronic bronchitis
    - COPD/emphysema
    - other:____

17. Do you have difficulty breathing? Circle one: **YES / NO**

If no, skip to question 21.

18. If the answer is yes, please mark the following that apply to you:
   - o breath holding
   - o breaths feel unsatisfying
   - o chest tightness
   - o difficulty exhaling/getting air out
   - o difficulty inhaling/getting air in or enough air
   - o elimination of symptoms with allergy medications
   - o elimination of symptoms with asthma medications
   - o excessive yawning, gasping or sighing
   - o related to coughing episodes
   - o breathe from mouth
   - o noisy breathing/stridor
   - o run out of air while speaking
   - o throat tightness
   - o waking from sleep with SOB
   - o worse when stressed

19. What triggers your shortness of breath?
   - o talking
   - o laughter
   - o humidity
   - o airborne irritants (e.g. bleach, cleaners, perfumes, potpourri, candles, gasoline, etc.)
   - o extreme temperature changes (e.g. going from air-conditioned building to hot car)
   - o physical exercise/exertion
   - o lying down

20. How often does shortness of breath occur and how long does it last?
   - o daily
   - o multiple times per day
   - o weekly
   - o monthly
   - o lasting less than 5 minutes
   - o lasting longer than 5 minutes
   - o several hours
   - o continuous

21. Do you experience any of the following reflux related symptoms?
   - o acid or water brash (acidic liquid coming up into throat)
   - o bad breath/halitosis
   - o bitter or metallic taste in mouth
   - o burping/belching
   - o chronic bronchitis
   - o heartburn
   - o increased or chronic post-nasal drip in absence of season
   - o indigestion
   - o regurgitation of food or liquid
   - o sudden coughing after lying down
   - o tooth decay
   - o voice worse upon waking
   - o waking from sleep with coughing, shortness of breath, or reflux symptoms
   - o "I don't have these symptoms because my reflux medication stops all of these symptoms"

22. If you have any of the symptoms listed in previous question, please indicate how often in the last month symptoms have been present:
   - o daily
   - o multiple times per day
   - o weekly
   - o multiple times per week
   - o monthly
   - o multiple times per month

Patient Name:______________________________ **Date:**____________________

23. Do you experience sensations in your throat? Circle one: **YES / NO**
    If no, skip to question 29.

24. Do you experience any of the following sensations in your throat?
    - o aching
    - o burning
    - o dryness
    - o irritation
    - o lump in throat
    - o soreness
    - o tickling
    - o tightness

25. When are the above sensations present?
    - o better during swallowing
    - o comes on during day associated with talking
    - o continuous throughout day
    - o present more often after eating
    - o upon waking
    - o worse during swallowing

26. Frequency of throat symptoms?
    - o sometimes
    - o often
    - o always

27. Severity of throat symptoms?
    - o mild
    - o moderate
    - o severe

28. Do you feel the sensation in a specific location?
    - o both sides of neck
    - o front of neck at base in center
    - o front of neck middle
    - o left side only
    - o right side only
    - o throughout throat

29. How much of the listed beverages do you drink daily?
    - o more than 8 cups/64 oz. per day of water
    - o less than 8 cups/64 oz. per day of water
    - o caffeine servings per day: 1-2 3-4 4 or more
    - o alcohol servings per day: 1-2 3-4 4 or more
    - o other non-alcoholic beverages: 1-2 3-4 4 or more

30. Do you smoke cigarettes, vape, or use substances of any kind? Circle one: **YES / NO**
    If yes, please list type of substance and amount: ______________________________

Patient Name:____ **Date:**__________________________

31. Do you have difficulty swallowing? Circle one: **YES / NO**
If no, you have completed the questionnaire.

32. If the answer is yes, please mark the following that apply:
- o coughing after eating
- o difficulty clearing throat of food
- o food or liquid goes down wrong way
- o problems occur:
  - o at the beginning of meal
  - o at the end of meal or immediately after meal
  - o within an hour of eating
- o avoiding certain food and/or liquid
- o takes longer to eat
- o items causing above symptoms:
  - o solids
  - o liquids
  - o dry/stringy foods
  - o small foods or foods that break into small pieces
  - o pills
  - o saliva

33. Have you had any of the following studies in the past?
- o allergy testing
- o cardiac testing
- o chest X-ray
- o esophagram – test involving drinking barium liquid and tablet while placed in different positions in radiology
- o laryngoscopy
- o methacholine challenge test to confirm asthma
- o modified barium swallow (MBSS) – test involving eating foods and liquids with barium presented by speech pathologist in radiology suite
- o pulmonary function test (PFT)
- o speech therapy (for these symptoms)
- o upper GI/ esophagoscopy

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DYSPNEA SEVERITY INDEX (DSI)

Name: ____ Date: ___/___/___

These are some symptoms that you may be feeling. Please circle the response that indicates how frequently you experience the same symptoms.
(0 = never, 1 = almost never, 2 = sometimes, 3 = almost always, 4 = always)

1.	I have trouble getting air in.	0	1	2	3	4
2.	My breathing problem causes me to restrict my personal and social life.	0	1	2	3	4
3.	My shortness of breath gets worse with stress.	0	1	2	3	4
4.	The change in weather affects my breathing problem.	0	1	2	3	4
5.	My breathing gets worse with stress.	0	1	2	3	4
6.	I have to strain to breathe.	0	1	2	3	4
7.	It takes more effort to breathe than it used to.	0	1	2	3	4
8.	My breathing problem upsets me.	0	1	2	3	4
9.	My shortness of breath scares me.	0	1	2	3	4
10.	My breathing problem makes me feel stressed.	0	1	2	3	4

Total: _____**/40**

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Cough Severity Index (CSI)

Name: ______________________________ Date: _____ / _____/ _____

These are some symptoms that you may be feeling.
Please circle the response that indicates how frequently you experience the same symptoms.
(0 - never, 1 - almost never, 2 - sometimes, 3 - almost always, 4 - always).

1. My cough is worse when I lie down. 0 1 2 3 4
2. My coughing problem causes me to restrict my personal and social life. 0 1 2 3 4
3. I tend to avoid places because of my cough problem. 0 1 2 3 4
4. I feel embarrassed because of my coughing problem. 0 1 2 3 4
5. People ask, "What's wrong?" because I cough a lot. 0 1 2 3 4
6. I run out of air when I cough. 0 1 2 3 4
7. My coughing problem affects my voice. 0 1 2 3 4
8. My coughing problem limits my physical activity. 0 1 2 3 4
9. My coughing problem upsets me. 0 1 2 3 4
10. People ask me if I am sick because I cough a lot. 0 1 2 3 4

Score: __________

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Voice Center New Patient Questionnaire

Date: ____________________

Patient Name: ____________________________________ DOB: __________________

1. What is the reason for your visit today? ____________________________________
2. When did your symptoms start? ____________________________________
3. Were there any associated illness, factors, or conditions at the time of onset?

   ____

4. How would you describe your symptoms?
   - Mild
   - Moderate
   - Severe
   - Sudden onset
   - Gradual onset

5. Do you have any of the following symptoms?
   - Hoarseness
   - Fullness in throat
   - Difficulty swallowing
   - Difficulty breathing
   - Throat pain
   - Noisy breathing
   - Burning sensation in throat
   - Excessive throat mucus
   - Feeling something stuck in throat
   - Heartburn/regurgitation
   - Chronic cough
   - Throat clearing
   - Voice Change

6. How much do you drink of the following per day?
   - Caffeine per day _____________
   - Water per day _______________

7. Have you had any of the following studies in the past?
   - Pulmonary function test
   - Laryngoscopy
   - Methacholine challenge test
   - Modified Barium Swallow
   - Esophagram
   - Upper GI/ Esophagoscopy
   - FEES
   - Speech Therapy
   - Chest X-ray

8. If hoarse, how does this impact your life? ____________________________________
9. If having difficulty swallowing, what foods/liquids are problematic?

   ____

VOICE HANDICAP INDEX-10 (VHI-10)

Name: ______________________________ Date: ___/___/___

Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Please circle the response that indicates how frequently you experience the same symptoms.
(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 as though I have to strain to produce voice.	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

SCORE: ______________

What is your perception of the severity of your voice problem?

1	2	3	4	5	6	7

Least Severe — Most Severe

REQUIRED - ENTIRE FORM MUST BE COMPLETED

The Voice Center

PATIENT QUESTIONNAIRE

PATIENT NAME:____ **DATE:**____________________

Date of Birth: ______________ Age:_______ Height:_______ Weight:_______ Gender: Male _____ Female ______

Marital Status:______________ Occupation:________________________ Referring Physician:_______________

Primary Care Doctor: ________________________________ Pediatrician: _________________________________

ARE YOU CURRENTLY ENROLLED IN HOME HEALTH CARE (do you have home nurse visits, speech, physical or occupational therapy at your home?) Please circle **Y N**

REASON FOR CURRENT DOCTOR VIST: Explain problem/s and duration: ____

____

PERSONAL MEDICAL HISTORY: Please check all that apply: [] None Apply

- [] High blood pressure
- [] Diabetes
- [] Thyroid disease
- [] Heart disease
- [] Infectious Disease (HIV, TB, Hepatitis, etc): ____________________
- [] Lung Disease (Asthma, Emphysema, etc): ____________________
- [] Cancer: ____
- [] Other (List) ____

REVIEW OF SYSTEMS: Check the appropriate box; if yes, explain briefly below [] None Apply

- [] Vision problems
- [] Lung problems
- [] Heart problems
- [] Kidney problems
- [] Liver problems
- [] Stomach problems
- [] Bleeding problems
- [] Endocrine problems
- [] Musculoskeletal problems
- [] Neurologic problems
- [] Psychiatric problems
- [] Skin problems

Explain if yes: ____

PRIOR SURGERIES: Please list with dates

[] No surgeries

____

____

____

FAMILY HISTORY: List family member and as related to your current problem

____

____

____

MEDICATIONS: [] No Medications

<u>Medication</u> <u>Dose</u> <u>How often taken</u>

____

____

____

____

____

Please list others on the back of this sheet

ALLERGIES TO MEDICINES: [] No Allergies

List medicine and reaction

____

____

____

Are you pregnant: [] Yes [] No

If yes, how many months? __________

SOCIAL HISTORY:

City of Birth: ______________________How long in TX____________

Do you smoke? Y/N If yes, # of packs/day?____ How many years?___

If no, have you ever smoked?_____ When did you quit?___________

Do you drink alcohol? Y/N If yes, how much, how often?____________

PHARMACY:

Pharmacy Name: _________________________

Pharmacy Address: _______________________

Pharmacy Phone: _________________________