UNIVERSITY SPEECH, LANGUAGE AND HEARING CLINIC
A UNITED WAY FACILITY
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Please provide, to the best of your ability, the following information.. If a question is not applicable, place an NA in the space provided. If you need more space to answer a particular question, you may wish to attach a separate sheet.

VOICE CASE HISTORY FORM - ADULT

Name ____________________ Birthdate ____________ Sex ____________

Address ____________________ City ____________ , State ________ Zip ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Informant ____________________ Relationship to client ____________________

Profession ____________________ Employer ____________________

Name of Family Physician (optional) ____________________

Address ____________________ City ____________ State ________ Zip ____________

Have you been examined by an Ear, Nose and Throat Physician?_____ If so when? ____________

Name of E.N.T. Physician ____________________

Address ____________________ City ____________ State ________ Zip ____________

DESCRIBE THE VOICE PROBLEM: ____________________

____

____

____

HISTORY OF VOCAL PROBLEM:

What do you think caused your voice problem? ____________________

____

What is your opinion about the sound of your voice? ____________________

____

What do you think should be the ideal voice for you? ____________________

____

What is the reason for seeking help at this time? ____________________

____

How do your family, friends, teachers, employers regard your voice?_______________

____

____

ORIGIN AND DEVELOPMENT OF VOICE PROBLEM:

Describe the circumstances under which the voice problem was first noticed:_______________

____

Suddenly developed? _______________ Gradually developed?_______________

Duration of problem? _______________ Who first noticed the problem? _______________

Check below if you did any of the following before noticing the problem:

Shouting ( ) Screaming ( ) Extensive speaking ( )

Singing ( ) Dramatics ( ) Have you received voice/singing training or acting training? _______________

If so, which?_______________

Had you had an illness or surgery about the time of onset? ________If so, please describe: _______________

____

____

MEDICAL HISTORY:

If you have been examined by an E.N.T., what were the diagnosis and recommendations? _______________

____

____

Check diseases and/or conditions you have had and state age of occurrence. Indicate any that affected voice with an asterisk (*)

Disease/Condition	Age of occurrence	Disease/Condition	Age of Occurrence
Measles ( )	________	Mumps ( )	________
Chicken Pox ( )	________	Whooping Cough ( )	________
Diphtheria ( )	________	Rheumatic Fever ( )	________
Poliomyelitis( )	________	Scarlet Fever ( )	________
Mononucleosis ( )	________	Cancer ( )	________
Pneumonia ( )	________	Anemia ( )	________
Hear Disease ( )	________	Glandular Disturbances ( )	________
Asthma ( )	________	Post Nasal Drip ( )	________
Tinnitus-ringing in the ear ( )	________	Mouth Breather ( )	________
Retarded Sexual Development ( )	________	Allergies ( )	________
Chronic Sinus Attacks ( )	________	Thyroid Problems ( )	________
Chronic Cough ( )	________	Chronically tired ( )	________
Nasal Congestion ( )	________	Dry Skin and/or Hair ( )	________
Numbness ( )	________	Dizziness ( )	________

Dryness in nose and/or mouth ( ) ______________ Sluggishness ( ) ________
Nervousness ( ) ______________ Average temperature below normal ( ) ________
Difficulty Swallowing ( ) ______________ Strained throat ( ) ________
Chilled when others are warm ( ) ______________ Body Aches ( ) ________
Others: ____

What injuries have you had (especially in the neck or throat areas)? ______________________

____

At what age did these injuries occur? ______________________

What surgery have you had? ______________ Date: ______________

What were the results of surgery? ______________________

Have you had your adenoids removed? __________ When? ______________

Deviated septum corrected? __________ Growths removed from nose or throat? __________

Thyroidectomy? ______________ Other: ______________

List medications you are taking currently and how long you have been taking each one:

____

____

List any drugs you have taken over an extended period of time in the past? ______________

____

Do you take vitamins? ______________ What type? ______________

What medications were you taking when your voice problem first appeared? ______________

____

Do you have pain or sensation in the throat or larynx? ______________________

____

Has water ever come out your nose? ______________________

Have you ever put anything up your nose or swallowed anything unusual? ______________

____

Do you have a history of laryngeal pathology: Growths? ________ Obstructions? __________

Inflammation? ______________ __________ Tickling? ______________

Describe: ____

____

HISTORY OF VOCAL USE

Check if any of the statements apply to you:

As an infant: excessive crying ( ) screaming ( ) yelling ( ) Did a hernia result from this? ( )

As a child, were you: talkative? ( ) vocally noisy? ( )

Was anything usual about the change of voice at puberty? At what age did your voice change? ________

____

Check any of the following that apply to you:

Have you experienced: Noisy breathing? ( ) Abnormal breathing? ( )

Complete loss of voice? ( ) If so, under what circumstances? ________________________

____

Have you been a cheerleader? ( )
Played contact sports? ( ) Any injury from contact sports? ________________________
Coordination problems? ( )
Period of prolonged use of voice? ( )
Exposure to fumes, chemicals, dust? ( )
Do you smoke now? ________ If so, cigarettes?( ) pipe? ( ) cigars? ( )
How much do you smoke? ________________ For how many years? ________________
If you do not smoke now, did you ever smoke? How recently? ____________
Do you drink alcohol? ____________ How much? ____________ For how many years? ______

What voice usage does your job or school involve? Explain ________________________

____

____

Any speech disorders or voice problems in your family? If so, describe____________________

____

Have you attempted to imitate anyone's voice before? ______________ If so, describe__________

____

Do you strain your voice at home? ____________ If so, describe the situation(s) in which this occurs:

____

Is your voice similar to anyone else in your family? ________________________

Are you closely associated with anyone who has a hearing loss? ____________________

Do people have difficulty understanding your speech? _____ If so, describe ______________

____

____

____

Consider each of the following items and check whether your voice is better or worse in these situations:

Time/Condition	Better		Worse
In the morning	( )		( )
In the afternoon	( )		( )
In the evening	( )		( )
At school	( )		( )
At home	( )		( )
When you are tired	( )		( )
When you are happy	( )		( )
When you are depressed	( )		( )
In different seasons	( )		( )
During weather changes	( )		( )
In certain places	( )		( )
With certain people	( )		( )

Other (please explain) ______

Have you had voice therapy previously? ______ If so, when? ______

With Whom? ______

Address ______ Zip______

Describe what you did in therapy: ______

______

What were the results of therapy? ______

Why was it terminated? ______

What else have you done to help your voice? ______

______

PSYCHOLOGICAL/SOCIOLOGICAL INFORMATION

How would you describe yourself? Happy ( ) Sad ( ) Optimistic ( ) Pessimistic ( )

Name three things you fear: ______

Do you become angry easily? ______ Explain: ______

How do you like your job? ______

If you could do any kind of work, what would you choose?______

If you had three wishes, what would they be? ______

______

ADDITIONAL QUESTIONS OR COMMENTS: (continue on back of page if needed)

______

______

Return this completed form as promptly as possible. Once we receive the form, we will we contact you to set up the evaluation you have requested.