Voice and Swallow Clinics

Medical Intake Form for **NEW Breathing/Cough** Patients

Date: _____

MRN (Staff Input) _____

Name: _____

Date of Birth: _____ Age: _____

Occupation: _____ (Circle) full-time / part-time / unemployed / retired / disabled

› How did you hear about our UW Health Voice and Swallow Clinics?

- ☐ Community education
- ☐ Radio
- ☐ Newspaper
- ☐ Public event
- ☐ From medical referrals
- ☐ Other, please list_____

› You were referred to this clinic by your:

- ☐ Primary care doctor
- ☐ Otolaryngologist
- ☐ Speech pathologist
- ☐ Self
- ☐ Other_____

Name of person who referred you_____

Referring clinic (name) _____

Location (city, state) _____

› Primary concern today:

- ☐ Breathing
- ☐ Cough
- ☐ Other: _____

1. Current concerns/symptoms

› When did you first become concerned about your problem (estimate date)? _____

› Did the problem begin suddenly or gradually? ☐ Suddenly ☐ Gradually ☐ Not sure

› Is it getting? ☐ Better ☐ About the same ☐ Worse

› Have you had prior problems with breathing, cough, or frequent throat-clearing? ☐ Yes ☐ No

› Do you have a cough? ☐ Yes ☐ No

If yes, for how long? ☐ Less than 1 month ☐ 2-6 months ☐ 7-12 months ☐ More than a year

What triggers the onset of the cough? _____

› Are you an athlete? ☐ Yes ☐ No

If yes, which type? ☐ Elite (Professional, Triathlon, Marathon, University)
☐ Competitive
☐ Regular daily exercise

› Have you ever been treated for asthma? ☐ Yes ☐ No (if no, skip to Section 2)
If you were treated for asthma;

How long ago? ☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than a year ago

Is your current difficulty the same as asthma? ☐ Yes ☐ No

If no, how is it different? _____

Were you prescribed inhalers for your asthma? ☐ Yes ☐ No

How long does it take the inhaler to work? ☐ 0-5 mins ☐ 15-20 mins ☐ More than 20 mins

2. Describe the nature of your present difficulty:

› Have you noticed any of the following with your breathing/cough symptoms? (check all that apply)

☐ Harder to breathe in than out
☐ Harder to breath out than in
☐ Tightness in chest
☐ Tightness in throat
☐ High pitched breathing/wheezing when you breathe in
☐ High pitched breathing/wheezing when you breathe out
☐ Voice changes

› How often do your breathing/coughing episodes occur? (please check appropriate responses)

	During Awake hours		During Sleeping hours	
Daily	☐ once	☐ multiple times	☐ once	☐ multiple times
Weekly	☐ once	☐ multiple times	☐ once	☐ multiple times
Monthly	☐ once	☐ multiple times	☐ once	☐ multiple times
Every 6 months	☐ once	☐ multiple times	☐ once	☐ multiple times
Yearly	☐ once	☐ multiple times	☐ once	☐ multiple times

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› What brings on your breathing/coughing/throat-clearing episodes (please check all that apply):

☐ Elite exercise	☐ Nighttime	☐ Walking	☐ Throat-clearing
☐ Competitive exercise	☐ Cold air	☐ Coughing	☐ Burping
☐ "Suicide drills" exercise	☐ Warm air	☐ Talking	☐ Sour taste
☐ Weekly exercise	☐ Perfumes	☐ Stress	☐ Regurgitation
☐ Practice only exercise	☐ Chemical odors	☐ Laughing	☐ Bitter taste
☐ Competition only exercise	☐ Smoke	☐ Sitting	☐ Heartburn
☐ Other _____	☐ Allergies	☐ Eating	☐ Illness/colds

› When was your last event? _____ (month, year)

› How long is a typical event? _____ (minutes)

› How long does it take for your symptoms to resolve? _____ minutes / hours / days (circle one)

› If your symptoms are triggered by exercise, how long can you typically exercise before the symptoms begin? _____ minutes

› How quickly can you resume your activity after an event? _____ minutes

› When you resume your activity, does the problem come back? ☐ Yes ☐ No ☐ Sometimes

› Does anything help you when you have trouble breathing or coughing? ☐ Yes ☐ No

If yes, please describe _____

› Have you stopped doing any of these activities because of your difficulties with breathing, cough, or throat clearing? ☐ Work ☐ Social ☐ Physical ☐ None ☐ Other _____

3. Medical history

› Have you had therapy for your breathing/coughing concern? ☐ Never ☐ Yes, in past ☐ Yes, currently
if yes, please describe:

Number of sessions _____ (#/wk) for the period of time _____ (months)
Length of each session _____ (minutes)
Service provider _____ location (city, state) _____
Approximate date when therapy started _____ when therapy ended _____
Goals of therapy _____
Was the therapy beneficial? ☐ Yes ☐ No

› How much of the following do you consume?

Water	☐ None	☐ 1 cup/day	☐ 2-4 cups/day	☐ 5-8 cups/day	☐ More than 8 cups/day
Caffeinated beverages	☐ None	☐ 1 cup/day	☐ 2-4 cups/day	☐ 5-8 cups/day	☐ More than 8 cups/day
Carbonated beverages	☐ None	☐ 1 cup/day	☐ 2-4 cups/day	☐ 5-8 cups/day	☐ More than 8 cups/day

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› How often do you have a drink containing alcohol?

☐ Never
☐ Monthly or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week
☐ Other _____

How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ NA ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or more

› Do you smoke cigarettes?

☐ Never
☐ Yes, in the past: packs per day _____; Number of years _____; Quit in _____ (month/year)
☐ Yes, currently: packs per day _____; Number of years _____

› Have you smoked cigars/pipes or chewed tobacco? (If yes, please check which)

☐ Never ☐ cigars ☐ pipes ☐ chewed tobacco number of years: _____

› Have you had chronic exposure to second-hand smoke? ☐ Yes, number of years : _____ ☐ No

› Have you been exposed to any chemicals frequently, or recently, at home ore at work?

☐ Never
☐ Yes, in the past please explain: _____
☐ Yes, currently please explain: _____

› Do you have the following allergies?

Seasonal	☐ Yes, list: _____	☐ No
Environmental (dust, etc.)	☐ Yes, list: _____	☐ No
Food	☐ Yes, list: _____	☐ No
Medication	☐ Yes, list: _____	☐ No

› What type of medications do you take for your allergies (check all that apply):

☐ None ☐ Prescription ☐ Over the counter ☐ Saline rinse ☐ Other _____

Please list the names of your allergy medications: _____

› Have you had surgery to your neck, throat, or vocal cords? ☐ Yes, number of times : _____ ☐ No

Date(s) of surgery(surgeries) _____

Your current voice, compared to before surgery, is: ☐ Worse ☐ Better ☐ Same

› Have you ever had radiation therapy to the head, neck or chest? ☐ Yes ☐ No

› Please indicate other medical procedures or surgeries you have had:

_____

› Please describe any serious accidents or injuries in your past. When did this happen?

_____

› Please list any medical conditions you are being treated for:

_____

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SF-12v2® Health Survey Standard Version

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. **In general, would you say your health is:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:			
b. Climbing several flights of stairs:			

3. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular activities as a result of your physical health?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like					
b. Were limited in the kind of work or other activities:					

4. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like:					
b. Did work or activities less carefully than usual					

5. **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?** ☐ Not At All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ Extremely

6. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?					
b. Did you have a lot of energy?					
c. Have you felt downhearted and depressed?					

7. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

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4. Please rate how the following problems have affected you within the past month

	"0" = No problem					"5" = Severe problem
Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or post nasal drip	0	1	2	3	4	5
Difficulty swallowing foods, liquids, or pills	0	1	2	3	4	5
Coughing after you eat or lie down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat, or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5
	(For staff input only) **RSI score**: _____					

5. Please rate how the following problems have affected you within the past month

	Score = 0	Score = 1	Score = 2	Score = 3
Feeling nervous, anxious, or on edge?	Not at all	Several days	More than half the days	Nearly everyday
Not being able to stop or control worrying?	Not at all	Several days	More than half the days	Nearly everyday
Worrying too much about different things?	Not at all	Several days	More than half the days	Nearly everyday
Trouble relaxing?	Not at all	Several days	More than half the days	Nearly everyday
Being so restless that it is hard to sit still?	Not at all	Several days	More than half the days	Nearly everyday
Becoming easily annoyed or irritable?	Not at all	Several days	More than half the days	Nearly everyday
Feeling afraid as if something awful might happen?	Not at all	Several days	More than half the days	Nearly everyday

› If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle one)

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

(for staff input only) Total score: _____

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We want to understand more about how your voice problem can interfere with your day-to-day activities. Please circle the response that indicates how frequently you have had the same experience in the last month. There are no "right or wrong" answers.

	Never	Almost Never	Some of the time	Almost Always	Always
1. My voice makes it difficult for people to hear me.	0	1	2	3	4
2. I run out of air when I talk.	0	1	2	3	4
3. People have trouble understanding me in a noisy room.	0	1	2	3	4
4. The sound of my voice varies throughout the day.	0	1	2	3	4
5. My family has difficulty hearing me when I call them throughout the house.	0	1	2	3	4
6. I use the phone less often than I would like.	0	1	2	3	4
7. I'm tense when I am talking with others because of my voice.	0	1	2	3	4
8. I tend to avoid groups of people because of my voice.	0	1	2	3	4
9. People seem irritated with my voice.	0	1	2	3	4
10. People ask "What's wrong with your voice?"	0	1	2	3	4
11. I speak with friends, neighbors, or relatives less often because of my voice.	0	1	2	3	4
12. People ask me to repeat myself when speaking face to face.	0	1	2	3	4
13. My voice sounds creaky and dry.	0	1	2	3	4
14. I feel as though I have to strain to produce voice.	0	1	2	3	4
15. I find other people don't understand my voice problem.	0	1	2	3	4
16. My voice difficulty restricts my personal and social life.	0	1	2	3	4
17. The clarity of my voice is unpredictable.	0	1	2	3	4
18. I try to change my voice to sound different.	0	1	2	3	4
19. I feel left out of conversations because of my voice.	0	1	2	3	4
20. I use a great deal of effort to speak.	0	1	2	3	4
21. My voice is worse in the evening.	0	1	2	3	4
22. My voice problem causes me to lose income.	0	1	2	3	4
23. My voice problem upsets me.	0	1	2	3	4
24. I am less outgoing because of my voice problem.	0	1	2	3	4
25. My voice makes me feel handicapped.	0	1	2	3	4
26. My voice "gives out" on me in the middle of speaking.	0	1	2	3	4
27. I feel annoyed when people ask me to repeat.	0	1	2	3	4
28. I feel embarrassed when people ask me to repeat.	0	1	2	3	4
29. My voice makes me feel incompetent.	0	1	2	3	4
30. I'm ashamed of my voice problem.	0	1	2	3	4

31. **My voice is** (please circle one):	Normal	Mildly impaired	Moderately impaired	Severely impaired

(for staff input only) **VHI scores** Functional _____ Physical _____ Emotional _____ Total _____

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If you are EXPERIENCING COUGH, please fill out this questionnaire, otherwise skip this section.
This questionnaire is designed to assess the impact of cough on various aspects of your life.
Read each question carefully and answer by CIRCLING the response that best applies to you.

Please answer ALL questions, as honestly as you can.

1. In the last 2 weeks, have you had chest or stomach pains as a result of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

2. In the last 2 weeks, have you been bothered by sputum (phlegm) production when you cough?

1	2	3	4	5	6	7
Every time	Most times	Several times	Some times	Occasionally	Rarely	Never

3. In the last 2 weeks, have you been tired because of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

4. In the last 2 weeks, have you felt in control of your cough?

1	2	3	4	5	6	7
None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time

5. How often during the last 2 weeks have you felt embarrassed by your coughing?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

6. In the last 2 weeks, my cough has made me feel anxious

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

7. In the last 2 weeks, my cough has interfered with my job, or other daily tasks

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

8. In the last 2 weeks, I felt that my cough interfered with the overall enjoyment of my life

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

9. In the last 2 weeks, exposure to paints or fumes has made me cough

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

10. In the last 2 weeks, has your cough disturbed your sleep?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

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11. In the last 2 weeks, how many times a day have you had coughing bouts?

1	2	3	4	5	6	7
All of the time (continuously)	Most times during the day	Several times during the day	Some times during the day	Occasionally through day	Rarely	None

12. In the last 2 weeks, my cough has made me feel frustrated

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

13. In the last 2 weeks, my cough has made me feel fed up

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

14. In the last 2 weeks, have you suffered from a hoarse voice as a result of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

15. In the last 2 weeks, have you had a lot of energy?

1	2	3	4	5	6	7
None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time

16. In the last 2 weeks, have you worried that your cough may indicate serious illness?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

17. In the last 2 weeks, have you been concerned that other people think something is wrong with you, because of your cough?

1	2	3	4	5	6	7
All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

18. In the last 2 weeks, have you suffered from a hoarse voice as a result of your cough?

1	2	3	4	5	6	7
Every time	Most times	A good bit of the time	Some of the time	A little of the time	Hardly any of the time	None of the time

19. In the last 2 weeks, I feel that my cough has annoyed my partner, family or friends

1	2	3	4	5	6	7
Every time I cough	Most times when I cough	Several times when I cough	Some times when I cough	Occasionally when I cough	Rarely	Never