University of Wisconsin-Madison

# Voice & Swallow Clinics

## Medical Intake Form for Voice 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 UWHC 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:**
  - □ Voice Effort
  - □ Voice Quality
  - □ Voice Quality and Effort
  - □ Other: _____

*Continued on next page*

1. **Current voice concerns/ symptoms:**

- When did you first become concerned about your vocal problem (estimate date)?_____
- Did the problem begin suddenly or gradually? □ Suddenly □ Gradually □ Not sure
- Is it getting: □ Better □ About the same □ Worse
- What do you think caused the onset of your vocal difficulty? (check all that apply)

□ An accident
□ Chemical exposure
□ Upper respiratory infection
□ Vocal abuse (yelling/screaming)
□ Emotional stress/anxiety
□ Medication
□ Increased voice use
□ Surgery
□ Unknown
□ Other, _____

- Please indicate the nature of your present vocal difficulties:

□ **NONE**
□ Hoarseness (raspy or scratchy sound)
□ Breathiness in speaking voice
□ Fatigue (voice tires or quality changes)
□ Voice breaks
□ Whisper only (total loss of voice)
□ Trouble speaking softly
□ Trouble speaking loudly
□ Voice is lower
□ Voice is higher
□ Voice is weaker
□ Vocal strain
□ Periods of normal voice
□ Sore throat
□ Lump in throat
□ Trouble singing
□ Tickling or choking sensation
□ Difficulty swallowing
□ Frequent throat clearing
□ Frequent dry throat
□ Frequent coughing
□ Nasality
□ Difficulty with the telephone

- Are these symptoms worse at certain times of the day (e.g., morning, afternoon or evening)?
- Are these symptoms worse during certain seasons (e.g., winter, spring, summer, fall)?
- Have you experienced any of the following in recent months (check all that apply):

□ Excessive sweating
□ Weight gain:_____ lbs in weeks / months (circle one)
□ Weight loss:_____ lbs in weeks / months (circle one)
□ Palpitation (fluttering) of the heart
□ Emotional/mood swings
□ Clumsiness in arms or legs
□ Shaking or tremors in your body movements
□ Double vision
□ Numbness of the face or extremities
□ Tingling around the mouth or face
□ Blurred vision or blindness
□ Weakness or paralysis of the face
□ Confusion or loss of consciousness
□ Memory change

2. **Voice Use:**

- Do you feel your voice is a necessity for your job? □ Yes □ No □ Not applicable
- Besides talking, you also use your voice for the following activities (check all that apply):

□ singing
□ acting
□ yelling/screaming
□ speaking over background noise
□ other (explain)_____
□ imitating other people's voices
□ using voice during strenuous exercise
□ teaching / lecturing / speaking for an audience
□ whispering

- You use your voice because you are a …(check all that apply):
  - □ parent to young children
  - □ phone operator
  - □ choral director
  - □ clergy
  - □ auctioneer
  - □ cheerleader
  - □ caretaker for someone with a hearing impairment
  - □ sports enthusiast
  - □ politician
  - □ other (explain)_____

- Voice use in general prior to current voice problems:
  □ Minimal □ Normal □ Moderate □ Heavy

- Voice use at home prior to current voice problems:
  □ Minimal □ Normal □ Moderate □ Heavy

- Voice use at work prior to current voice problems:
  □ Minimal □ Normal □ Moderate □ Heavy □ Not applicable

- Voice use outside work prior to current voice problems:
  □ Minimal □ Normal □ Moderate □ Heavy □ Not applicable

- Has your voice problem caused you to speak less? □ Yes □ No
  If yes, how much less? □ 25% □ 50% □ 75% □ 100%

- Are there things you have stopped doing because of your voice problems?
  □ Yes, list _____ □ No

**3. Medical history:**

- Have you had voice/speech therapy for your voice concern? □ Never □ Yes, in the 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 |

- 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?
  □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 or more

**Thank you for completing this questionnaire**

- 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_____

- If you have you smoked cigars, pipes or chewed tobacco,
  which type(s)? (please check) □ 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 or 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:

  _____

**Thank you for completing this questionnaire**

## 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 <u>your health now</u> limit you in these activities? If so, how much?**

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

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

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

**4. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (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. <u>Accomplished less</u> than you would like: | | | | | |
| b. Did work or activities <u>less carefully than usual</u> | | | | | |

**5. During the <u>past 4 weeks</u>, how much did <u>pain</u> 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 <u>during the past 4 weeks</u>. 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 <u>past 4 weeks</u>...**

| | 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? | | | | | |

**Thank you for completing this questionnaire**

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

___All of the time ___Most of the time ___Some of the time ___A little of the time ___None of the time



**4. <u>Please rate how the following problems have affected you within the past month</u>.**

**"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_____** | | | | | | |

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

**"0" = No problem, "5" = Severe problem**

| | | | | | | |
|---|---|---|---|---|---|---|
| Speaking took extra effort | 0 | 1 | 2 | 3 | 4 | 5 |
| Throat discomfort or pain after using your voice. | 0 | 1 | 2 | 3 | 4 | 5 |
| Vocal fatigue (voice weakening as you talk) | 0 | 1 | 2 | 3 | 4 | 5 |
| Voice "cracks" or sounds different | 0 | 1 | 2 | 3 | 4 | 5 |
| **For staff input only, Glottic Function Index:_____** | | | | | | |

**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.**

**PLEASE CHOOSE ONE AND ONLY ONE ANSWER FOR EACH QUESTION. IF A QUESTION DOES NOT APPLY TO YOU, PLEASE CHOOSE "0".**

| | 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 |

**Thank you for completing this questionnaire**

| | Never | Almost Never | Some of the time | Almost always | Always |
|---|---|---|---|---|---|
| 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 |

| My voice is: (please check one) | Normal | Mildly impaired | Moderately impaired | Severely impaired |
|---|---|---|---|---|
| For staff input only VHI Scores | Functional | Physical | Emotional | Total |

**Thank you for completing this questionnaire**