Tufts Medical Center

Patient History Form

PLEASE BE AS COMPLETE AS POSSIBLE WHEN FILLING OUT THIS FORM.

Name:

Age:

PCP & Referring Physician's Name and Address, if known:

_____

_____

What brings you to our office today? (**Chief Complaint**):_____

_____

_____

Past History(medical problems): PLEASE CIRCLE Y or N for all items:

Heart Disease	Y	N	Anxiety Disorder	Y	N
Lung Disease or Asthma	Y	N	Panic Attacks	Y	N
Deep Vein Thrombosis	Y	N	Depression	Y	N
High Blood Pressure	Y	N	Head and Neck Cancer	Y	N
Nasal Allergies	Y	N	Other Cancer	Y	N
Stroke or TIA	Y	N	Head Trauma	Y	N
Diabetes	Y	N	Seizures	Y	N
Thyroid Problems	Y	N	Bleeding Disorders	Y	N
GERD/Reflux	Y	N	Other Blood disorder	Y	N
Kidney Problems	Y	N	Arthritis	Y	N
Hepatitis/Liver Disease	Y	N	Nasal Allergies	Y	N

Other:_____

Have you had any of the following **surgeries**? PLEASE CIRCLE Y or N for all items:

Tonsillectomy/Adenoidectomy	Y	N	Facial Plastic Surgery	Y	N
Head and Neck Surgery	Y	N	Spine Surgery	Y	N
Thyroid Surgery	Y	N	Sinus/Nasal Surgery	Y	N
Ear Surgery	Y	N	Sleep Apnea Surgery	Y	N

Other Surgical History:_____

Have you ever had a bad reaction to Anesthesia? Y N

Are you currently taking Aspirin, ibuprofen or other NSAIDS daily? Y N

Are you taking any herbal or natural medicines? Y N If Yes, list_____

Are you allergic to any medications? Y N If Yes, list_____

Continued on other side

Family History - Circle any of the following diseases that run in your family:

Diabetes	Mother	Father	Sister/brother	Grandparent
Heart Disease	Mother	Father	Sister/brother	Grandparent
High Blood Pressure	Mother	Father	Sister/brother	Grandparent
Head and Neck Cancer	Mother	Father	Sister/brother	Grandparent
Cancer (Other :_____)	Mother	Father	Sister/brother	Grandparent
Easy bruising or bleeding	Mother	Father	Sister/brother	Grandparent

Other Diseases that run in your immediate family: _____
_____

Social History

Do you use tobacco products now or have you in the past? Y N
If cigarettes, how many packs per day_____
Number of Years you have/had smoked _____
If no longer smoking, how long ago did you quit? _____

Do you drink alcohol? Y N
If yes, how many drinks per day? _____ or per week?_____

What is your current or former occupation? _____

Review of Systems
Please CIRCLE Y or N for the symptoms that you may have **currently** or **recently** experienced:

Unexplained weight loss	Y	N	Fevers/Night sweats	Y	N
Change in Vision	Y	N	Heat/Cold Intolerance	Y	N
Dizziness	Y	N	Shortness of breath	Y	N
Chest Pain	Y	N	Bleeding/bruising easily	Y	N
Diarrhea	Y	N	Constipation	Y	N
Muscle or joint pain	Y	N	Trouble Swallowing	Y	N
Kidney/bladder problems	Y	N	Headaches	Y	N
Weakness or fatigue	Y	N	Numbness of face/hands/feet	Y	N

Other:_____

Thank you for taking the time to fill out this form. I realize that we have a lot of paperwork for you and your help is greatly appreciated.

Patient's or Guardian's Signature: _____Date:_____

Confirmed by:
Physician's Signature:_____Date:_____

Tufts Medical Center

THE CENTER FOR VOICE AND SWALLOWING

Name_____
Date_____

1-	____
2-	____
3- TALK	____
4- VHI-10	____
5- RSI	____
6- HADS*	____
HADS Δ	____

Voice Care Information Questionnaire

1. I use my speaking voice primarily for:
   - ~ A. my profession (teacher, minister, lawyer, salesperson, etc.)
   - ~ B. activities outside of work (coaching, community, organizations, etc)

2. I use my singing voice primarily for:
   - ~ A. my profession (singer-primary income, student of voice)
   - ~ B. activities outside of work (choir/chorus, singer/band member- secondary income)
   - ~ C. none of the above. I do not sing.

3. I would rate my degree of talkativeness as the following: (circle response)

1	2	3	4	5	6	7
Quiet Listener			Average Talker			Extremely Talkative

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4. VHI-10 **Instructions:** These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0 = Never
1 = Almost never
2 = Sometimes
3 = Almost always
4 = Always

My voice makes it difficult for people to hear me.	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My voice difficulties restrict personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
My voice makes me feel handicapped.	0	1	2	3	4
People ask "What's wrong with your voice?"	0	1	2	3	4

Please check that you have answered all the questions.

CONTINUED ON BACK ⇨

5. **RSI- <u>Instructions</u>:** These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

Within the last MONTH, how did the following problems affect you?

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 mucous	0	1	2	3	4	5
Difficulty swallowing food, liquids or pills	0	1	2	3	4	5
Coughing after eating or after lying 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

<u>Please check that you have answered all the questions.</u>