



MUSC EVELYN TRAMMELL INSTITUTE FOR VOICE AND SWALLOWING DISORDERS

Voice Evaluation - Case History Adolescent/Adult

Please fill out this form in black ink as completely as possible and bring to your scheduled appointment.

IDENTIFYING INFORMATION

Name: _____ Date: _____
Address: _____
Date of Birth: _____ Height: _____ Weight: _____ Age: _____ Sex: _____
Phone: _____ Home: _____ Work: _____
Employment: _____
Referred by: _____
Physician Address/Telephone #: _____
Physician Diagnosis: _____
Person completing form: patient, spouse, son, daughter, sister, brother, other _____
Name: _____

VOCAL HISTORY

- 1. Describe your voice problem: _____
2. Estimate the severity of the problem: [] Mild [] Moderate [] Severe
3. When did you first notice the voice problem? _____
4. Onset of problem: [] Sudden [] Gradual
5. Cause of voice problem: _____
6. Is the problem getting: [] Better [] Worse [] Same
7. Voice during the day: Better: [] morning [] afternoon [] evening
Worse: [] morning [] afternoon [] evening

8. Please check all that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Frequent throat clearing |
| <input type="checkbox"/> Fatigue (voice tires easily) | <input type="checkbox"/> Hard coughing |
| <input type="checkbox"/> Voice too loud | <input type="checkbox"/> Frequent yelling or loud talking |
| <input type="checkbox"/> Voice too soft | <input type="checkbox"/> Frequent whispering |
| <input type="checkbox"/> Pitch too high | <input type="checkbox"/> Aggressive personality |
| <input type="checkbox"/> Pitch too low | <input type="checkbox"/> Frequent exercise (grunting, lifting, aerobics) |
| <input type="checkbox"/> Frequent voice breaks | <input type="checkbox"/> Frequent thirst/dehydration |
| <input type="checkbox"/> Breathiness | <input type="checkbox"/> Hard and abusive laughter |
| <input type="checkbox"/> Tickling or choking sensation while talking | <input type="checkbox"/> Yelling at sporting event |
| <input type="checkbox"/> Tightness or tension in throat | <input type="checkbox"/> Night club social talking |
| <input type="checkbox"/> Pain in the throat while talking | <input type="checkbox"/> Calling from room to room in the house |
| <input type="checkbox"/> Losing your voice completely | <input type="checkbox"/> Calling children/friends or pets from a distance |
| <input type="checkbox"/> Nasality | <input type="checkbox"/> Exposure to dust, fumes, chemicals, etc. |
| <input type="checkbox"/> Straining or effort in speaking | <input type="checkbox"/> Loud or strenuous singing |
| <input type="checkbox"/> Sensation of phlegm in the throat | <input type="checkbox"/> Cheerleading or pep club |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Making toy, animal or character voices |

9. Situations that:

worsen your voice: _____

improve your voice: _____

10. Any previous voice problems? No Yes, describe

11. Any previous voice therapy?: No Yes, describe: _____

12. What medical treatments have you received for your voice problem? _____

13. Because of my voice problems:

My Work is impaired:						
1	2	3	4	5	6	7
Not at all	Mildly		Moderately		Markedly	Very Severely

My Social Life/Leisure Time is impaired:						
1	2	3	4	5	6	7
Not at all	Mildly		Moderately		Markedly	Very Severely

Check all that apply (continued)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cortisone/prednisone last 12 mo. | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Nephropathy |
| <input type="checkbox"/> Sinus problems/post nasal drip | <input type="checkbox"/> Thyroid dysfunction | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Heartburn/Indigestion/Reflux | <input type="checkbox"/> Polio | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Tubes, lines or drains |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Dentures | <input type="checkbox"/> Hearing aid(s) |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Trouble breathing | |
| <input type="checkbox"/> Neurologic problems (weakness, numbness, clumsiness, tremors/shaking, confusion) | | |
| <input type="checkbox"/> Assistive devices (prosthesis, cane, crutches, brace, walker, wheelchair) | | |
| <input type="checkbox"/> Pregnant now or within the last three months | | |

19. Current medications (prescribed and over-the-counter):

Medication	Dose	Frequency	Last dose (time/date)

20. Surgical history:

Surgery	Date	Surgery	Date

21. Substance Usage, Diet (check all that apply):

- Smoke _____ packs per day for _____ years
- Quit smoking, (date _____)
- Spit/chewing tobacco use
- Alcoholic beverages _____ per day. Type of alcohol _____
- _____
- Diet pills (name/amount/how long)
- Caffeine beverages _____ per day. Type of beverage: Cola Coffee Tea
- Water intake _____ glasses/ounces per day
- Other drug/substance usage: _____
- Special diet: _____

22. Blood Transfusion History (check all that apply):

- No blood transfusion history
- Yes, when _____ Reaction: _____
- Transfused within the last three months, date _____
- I have donated blood for myself
- Someone has donated blood for me
- I will accept a blood transfusion in an emergency situation to save my life**
- I will not accept a blood transfusion in an emergency situation to save my life**

23. Infectious Diseases

- No infections
- Tuberculosis
- AIDS/HIV positive
- Exposed to Measles/Mumps/Chicken Pox within the last three weeks
- Other: _____

24. Spiritual/Cultural/Ethnic Needs

- None
- List needs:

25. Do you feel the referral was appropriate: Yes No

26. What would you like to see from a voice evaluation and therapy? _____

27. List any additional information which may be helpful in assisting with your problem: _____

If you are a singer, please complete the following questions:

ARTISTIC VOCAL HISTORY

28. Have you had any formal voice training? Yes No
If yes, describe age, length and focus of training (ie, style and/or technique): _____

29. Presently studying with a voice teacher/ vocal coach? Yes No
If yes, teacher's name/address: _____

30. Have you ever had training for your speaking voice? Yes No
Acting lessons? Yes No

31. When did you begin to sing actively? _____

32. Any history of problems with your singing voice? Yes No
If yes, describe: _____

33. Any past voice problems that required a visit to a physician? Yes No
If yes, describe problem(s) and treatment(s): (ie, laryngitis, nodules, polyps, hemorrhage, other

34. Voice category: Soprano Mezzo-Soprano Alto Bass
 Tenor Baritone

35. Current status of your singing career: Professional Amateur

36. Current singing style: Pop Jazz/blues Classical
 Country Rock Opera
 Show Nightclub Other

37. Regular singing posture: Sitting Standing

38. Singing environments: Outdoors Large halls Orchestra
 Electrical instruments Other

39. Use monitor speakers if performing with electrical instruments/outdoors? Yes No

40. How often do you practice? _____

Length of practice: 15-30min 45-60 min 75-90 min 2hrs/more
Vocal scales: Daily 2-3x/wk 1x/wk Rarely Never
Songs: Daily 2-3x/wk 1x/wk Rarely Never

Do you warm up your voice before you sing? Yes No
Do you cool down your voice when you finish singing? Yes No

41. How many hours per day (average) are you singing at present (including practice time)?
Rehearsal: _____
Performance: _____

42. Singing range prior to vocal difficulties (if known) _____
Present singing range (if known): _____

43. Long-term career goals in singing:
 Premiere operatic career
 Professional music career
 Active avocation
 Amateur performance (choral or solo)
 Amateur singing for own pleasure
 Other; please describe: _____

