BASTIAN VOICE INSTITUTE
for voice, swallowing & airway disorders

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Downers Grove, IL 60515
Phone: 630-724-1100

NEW PATIENT QUESTIONNAIRE

Name _____ Date _____

Date of birth _____ Age _____ Occupation(s) _____

Primary care physician (*name, address*) _____

Who referred you to this office?

☐ **Physician** (*name, address*) _____
☐ Friend ☐ Voice teacher ☐ Speech pathologist
☐ Internet ☐ Television ☐ Newspaper
☐ Hospital ☐ Insurance company ☐ Professional organization
☐ Other _____

Please list anyone to receive a report of today's visit (if any) **in addition** to physician above:

1. Name _____ Phone _____
Address _____ City/State _____
2. Name _____ Phone _____
Address _____ City/State _____

PROBLEM OVERVIEW

What is the primary problem you need addressed? _____

_____

When and how did it begin? _____

Symptoms (limitations): What **can't** you do that you should be able to? _____

_____

Symptoms (aberrations): What does happen that **shouldn't**? _____

_____

Previous diagnosis and treatment elsewhere: _____

_____

Circle the number on the scale below which indicates how **severe** your problem seems to you.

No problem — *Moderate* — *Severe*

1 2 3 4 5 6 7

How **motivated** would you say you are to solve this problem?

Not motivated — *Moderately* — *Extremely*

1 2 3 4 5 6 7

ADDITIONAL VOCAL HISTORY

Please circle the number below which corresponds to how **talkative** you believe you are, *by nature* (not by occupation or other circumstance).

Very UNtalkative — *Average* — *Very talkative*

1 2 3 4 5 6 7

How would you describe the **loudness** of your conversational voice?

Very soft — *Average* — *Very loud*

1 2 3 4 5 6 7

Vocal commitments: _____

Any voice training? If so, number of years: ____ Teacher(s): _____

MEDICAL HISTORY

Check all that apply.

☐ *None apply*

☐ Heart attack
☐ Heart failure
☐ High blood pressure
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Kidney failure
☐ Gout
☐ **GERD**
☐ Diabetes
☐ Stroke
☐ Seizures
☐ Mental illness
☐ Kidney stones
☐ Blood clot in leg
☐ Osteoporosis
☐ Serious injury (*explain*) _____
☐ Lung disease
☐ HIV
☐ AIDS
☐ Tuberculosis
☐ Asthma
☐ Blood clot in lung
☐ Alcoholism
☐ Liver trouble
☐ Hepatitis
☐ Thyroid
☐ Bleeding
☐ Anemia
☐ Cancer
☐ Stomach ulcers

☐ Other: _____

SURGICAL HISTORY

List previous procedures you have had, if any. ☐ *None*

Operation	Surgeon	Date

MEDICATIONS

List any medications you take, if any. ☐ *None*

_____

_____

Do you have any **allergies** or **adverse reactions** to medications?
☐ No, none
☐ Yes (*please list*): _____

Do you have a living will?
☐ No
☐ Yes

SOCIAL HISTORY

Tobacco use:
☐ **Never**

<u>If current</u>:
☐ Cigarettes, __ packs/day for __ years
☐ Cigar ☐ Chew
☐ Pipe

<u>If former</u>:
☐ Cigarettes, __ packs/day for __ years
☐ Cigar ☐ Chew
☐ Pipe
Quit when? _____

Alcohol use:

☐ None at all
☐ 1–3 beverages per week
☐ 4–8 beverages per week
☐ 8+ beverages per week

Other:

Caffeinated beverages per day: ____
Total fluids (in cups) per day: ____

REVIEW OF SYSTEMS

Check all that apply.

☐ *None apply*

☐ Reading glasses
☐ Change of vision
☐ Loss of hearing
☐ Ear pain
☐ Toothache
☐ Nosebleeds
☐ Morning cough
☐ Shortness of breath
☐ Frequent belching
☐ Seizures
☐ Abnormal heartbeat
☐ Swollen ankles
☐ Calf cramps with walking
☐ Poor appetite
☐ Difficulty urinating
☐ Nausea/vomiting
☐ Stomach pain
☐ Ulcers
☐ Heart or chest pain
☐ Other: _____
☐ Frequent constipation
☐ Hemorrhoids
☐ Frequent urination
☐ Burning on urination
☐ Difficulty swallowing
☐ Recent weight change
☐ Frequent headaches
☐ Blackouts
☐ Heartburn
☐ Hot or cold
☐ Snoring, apnea
☐ Nervous
☐ Chronic pain
☐ Gum trouble
☐ Frequent spotting
☐ Irregular periods
☐ Fever or chills
☐ Skin rash

FAMILY HEALTH HISTORY

Please complete the following family history information for your records by indicating each blood relative (**Mother, Father, Sister, Brother, Daughter, Son, Twin**) who is affected by the following:

☐ Check here if none apply

☐ Adopted, no known biological family health history

Allergies	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Asthma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Autoimmune disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Blood disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
* Type/age of onset:							
Cardiovascular disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Chronic otitis media	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Coronary artery disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Deafness	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Depression	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Developmental delay	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
High cholesterol	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Genetic disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
GERD	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Hearing disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Migraines	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Obesity	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Osteosclerosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Renal disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Seizure disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Sickle cell disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Sleep apnea	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Thyroid disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Other (please specify):							
Deceased	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin

Thank you for filling out this questionnaire!