BASTIAN VOICE INSTITUTE
for voice, swallowing & airway disorders

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NEW PATIENT QUESTIONNAIRE: COUGH OR LARYNGOSPASM

Before you fill out this form: *If you will wish to save and email this form to us once completed,* ***be sure that you are using Adobe Reader XI****. Go to "Help"→ "About Adobe Reader __" (Windows) or "Adobe Reader"→ "About Reader" (Mac) to check your version. If you use Adobe Reader X or earlier to fill this out and email it to us, we will receive a blank form! Thus, if you have version X or earlier of Adobe Reader, you must either update to version XI before filling out and saving this form, or else you may fill out the form and print it out, without saving it electronically.*

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

When did your **coughing** or laryngospasm problem begin?

_____
_____

At the beginning, what was it that seemed to start the **cough** or laryngospasms? **Please check all that apply.**

☐ Upper respiratory infection ☐ Bronchitis or pneumonia ☐ Surgery on my neck
☐ Surgery on my chest ☐ **Other:** _____

Do you experience any sensation (even a subtle one) just before **coughing** or a laryngospasm begins?

☐ No
☐ Yes, and it is like a... (*check all that apply*)
☐ Sudden tickle ☐ Sudden "dry patch"
☐ Sudden burning ☐ Feeling of a "crumb caught in my throat"
☐ Jabbing or stabbing sensation ☐ **Other:** _____
... and this sensation is typically located at:
_____

Are you aware of anything that sometimes triggers your **coughing** or laryngospasms?

☐ No
☐ Yes; the triggers include (*check all that apply*):
☐ Talking ☐ Laughing ☐ Breathing cold air ☐ Breathing warm air
☐ Eating ☐ Swallowing ☐ Touching a spot on my neck
☐ Posture change, especially at night ☐ **Other:** _____
The *main* trigger is (*if there is one*): _____

PROBLEM OVERVIEW (CONTINUED)

Which of the following, if any, happens to you when you have severe **coughing** or a laryngospasm? **Please check all that apply.** (These are common experiences for many with severe coughing or laryngospasms.)

- ☐ I turn red
- ☐ My nose runs
- ☐ I *almost* throw up
- ☐ I *almost* pass out
- ☐ My eyes tear up
- ☐ I lose urine
- ☐ I *do* throw up
- ☐ I *do* pass out
- ☐ I have sudden, intense difficulty breathing (*laryngospasm*)
- ☐ I have broken one or more ribs
- ☐ **Other:** _____

Please estimate about **how many coughing episodes you have each day** (keep in mind that one "episode" could be short or long, from just one isolated cough to a prolonged series of coughs).

Total number of episodes per day (**of <u>any</u> duration**): _____

Number of episodes per day that last **at least 5 seconds**: _____

Number of episodes per day that last **at least 20 seconds**: _____

On average, how many times per day do you have a **laryngospasm** attack? *Daytime:* _____ *Nighttime:* _____

Most people with your problem say that it is roughly the same week after week. Some, however, notice periods of greater or lesser severity. Which is the case for you? **Please check the answer that best applies.**

- ☐ Roughly the same since onset
- ☐ Varies from week to week
- ☐ Varies from month to month
- ☐ May have long periods that are relatively symptom-free

If your cough or laryngospasm varies, is there any discernible pattern? **Please check all that apply.**

- ☐ The problem worsens following an upper respiratory infection (e.g., a cold)
- ☐ The problem seems to be tied to the change of seasons
- ☐ **Other:** _____
- ☐ *Not applicable* (the problem doesn't vary)

In what ways has this problem affected you? **Please check all that apply.**

- ☐ It hasn't—I just carry on and cope.
- ☐ I limit talking.
- ☐ I avoid public events when possible, for fear of making a disturbance with my coughing.
- ☐ I sleep alone so as not to disturb my bed partner.
- ☐ I've lost my job because of my coughing.
- ☐ I've had to change jobs because of my coughing.
- ☐ **Other:** _____

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

Minor annoyance — *Moderate* — *Ruining my life*

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

Is there anything else you would like to say about your problem?

_____

_____

PAST DIAGNOSES AND TREATMENTS

How many doctors do you think you have seen specifically for this problem? _____

How many in each of the following specialties? **Please check all that apply and give a number for each.**

Family doctor: ____ Internist: ____ Pulmonologist: ____
Ear, nose, and throat: ____ Psychiatrist: ____ Allergist: ____
Speech pathologist: ____ **Other:** _____

What tests have you had for your problem? **For each test you've taken, please indicate the test result.**

Test	**Normal result**	**or**	**Abnormal result**
Chest x-ray	☐		☐
CT scan	☐		☐
MRI	☐		☐
Pulmonary function test	☐		☐
Bronchoscopy	☐		☐
24-hour acid test	☐		☐
Esophagoscopy	☐		☐
Allergy test	☐		☐

What are you told is the cause of your **cough** or laryngospasms?

_____

_____

Which of these medications have you previously tried? **Please check all that apply.**

☐ Asthma inhalers ☐ Acid reflux medication ☐ Cough suppressant
☐ Antibiotics ☐ Expectorant ☐ Topical anesthetic
☐ Antihistamine (allergy) ☐ Amitriptyline (Elavil) ☐ Gabapentin (Neurontin)
☐ Oxcarbazepine (Trileptal)
☐ **Other 1:** _____ ☐ **Other 2:** _____ ☐ **Other 3:** _____

Did any medication ever seem to help noticeably?

☐ No
☐ Yes (*which ones, and how much did they help?*):

Medication: _____ Reduction of symptoms (1 to 100%): _____
Medication: _____ Reduction of symptoms (1 to 100%): _____

Have you tried any other treatments for your problem?

☐ No
☐ Yes; I have tried (*check all that apply*):

☐ Hypnosis ☐ Acupuncture ☐ Herbal remedies ☐ Vitamins
☐ **Other:** _____

Did any of the above alternative treatments seem to help?

☐ No
☐ Yes (*list any that helped*):

Treatment(s): _____

PAST DIAGNOSES AND TREATMENTS (CONTINUED)

Are you currently on or have you ever taken an ACE inhibitor generally used for blood pressure control?

☐ No

☐ Yes (*check all that apply*):

☐ Accupril (Quinapril) ☐ Inhibace (Cilazapril) ☐ Prinivil/Zestril (Lisinopril)
☐ Aceon (Perindopril) ☐ Lotensin (Benazepril) ☐ Univasc (Moexipril)
☐ Altace (Ramipril) ☐ Mavik (Trandolapril) ☐ Vasotec (Enalapril)
☐ Capoten (Captopril) ☐ Monopril (Fosinopril) ☐ Enalaprilat
☐ **Other:** _____

MEDICAL HISTORY

Check all that apply. ☐ *None apply*

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

SURGICAL HISTORY

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

Operation	Surgeon	Date

FAMILY HISTORY

Check all that apply. ☐ *None apply*

☐ Stroke ☐ Arthritis ☐ Mental illness ☐ Alcoholism
☐ Heart trouble ☐ Gout ☐ Kidney trouble or stones ☐ Seizures
☐ High blood pressure ☐ Bleeding disorders ☐ Spine problems ☐ Diabetes
☐ Chronic cough ☐ Asthma ☐ GERD/Acid reflux
☐ Neurological disorder: _____ ☐ Psychiatric disorder: _____
☐ Cancer: _____
☐ Other: _____

MEDICATIONS

List 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**

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

If former:
☐ 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
☐ Gum trouble
☐ Nosebleeds
☐ Frequent headaches
☐ Dizziness
☐ Blackouts
☐ Seizures
☐ Numbness or tingling

☐ Abnormal heartbeat
☐ Heart or chest pain
☐ Chronic pain
☐ Arthritis
☐ Calf cramps with walking
☐ Swollen ankles
☐ Cold intolerance
☐ Recent weight change
☐ Poor appetite
☐ Difficulty swallowing
☐ Stomach pain
☐ Other: _____

☐ Nausea/vomiting
☐ Fever or chills
☐ Frequent urination
☐ Burning on urination
☐ Difficulty urinating
☐ Frequent constipation
☐ Hemorrhoids
☐ Skin rash
☐ Hot or cold
☐ Irregular periods
☐ Frequent spotting

☐ Nervous
☐ Ulcers
☐ **Heartburn**
☐ **Acid belching**
☐ **Morning sore throat**
☐ **Morning cough**
☐ **Morning mucus**
☐ **Hoarseness**
☐ **Breathing problem**
☐ **Snoring**
☐ **Breath-holding at night**

FAMILY 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. When you are finished, please either save and email it back to us (**again, only possible if you are using version XI of Adobe Reader**) or else print it out at home and bring it when you come in.*