

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? _____

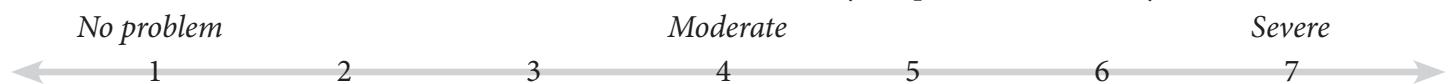
When and how did it begin? _____

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

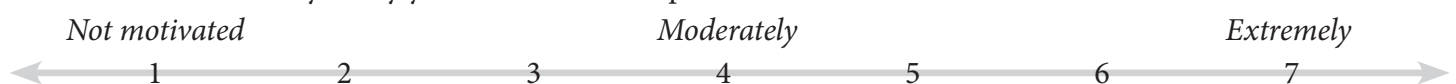
Symptoms (aberrations): What does happen that **shouldn't**? _____

Previous diagnosis and treatment elsewhere: _____

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

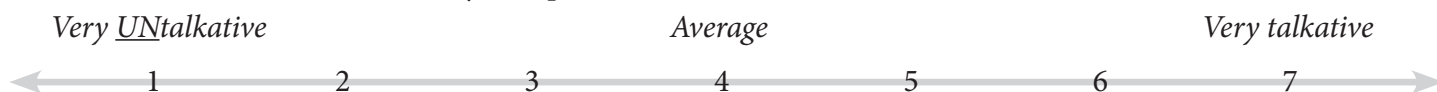


How **motivated** would you say you are to solve this problem?

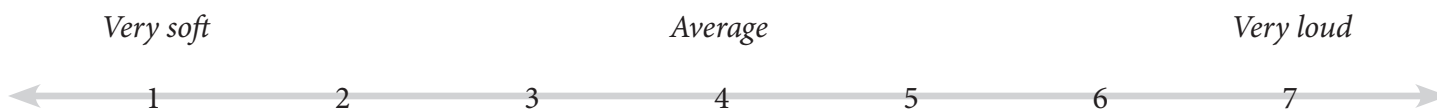


ADDITIONAL VOCAL HISTORY

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



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



Vocal commitments: _____

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

MEDICAL HISTORY

Check all that apply.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> <i>None apply</i> | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> AIDS | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Blood clot in lung | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Blood clot in leg | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoporosis | | |
| | <input type="checkbox"/> Serious injury (<i>explain</i>) _____ | | |

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

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.

Reading glasses

Change of vision

Loss of hearing

Ear pain

Toothache

Nosebleeds

Morning cough

Shortness of breath

Frequent belching

Seizures

None apply

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

Thank you for filling out this questionnaire!