Bastian Voice Institute
for voice, swallowing & airway disorders

3010 Highland Parkway, Suite 250
Downers Grove, IL 60515
Phone: 630-724-1100

NEW PATIENT QUESTIONNAIRE: INABILITY TO BELCH

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 and how did you become aware of your inability to belch?

____

____

Abdominal bloating? Explain.

____

____

What about gurgling noises? Describe.

____

____

Does it cause pain? If so, describe the nature, severity, location.

____

____

PROBLEM OVERVIEW (CONTINUED)

What is the main problem it causes?

Excessive flatulence?

Do you think your ability to vomit is different from other people? If so, describe.

To your knowledge, were you hard to burp as an infant? Were you gassy or colicky?

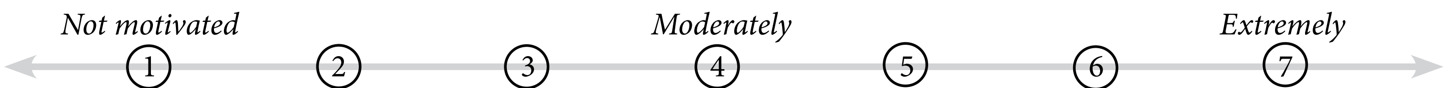
Do you experience heartburn or acid belching?

How does this problem affect your lifestyle? What adjustments have you made to your social life?

Previous diagnosis and treatment elsewhere:

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

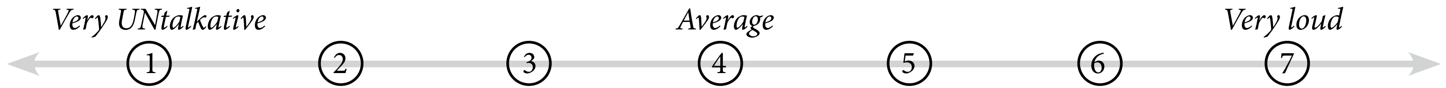
How **motivated** would you say you are to solve this problem?



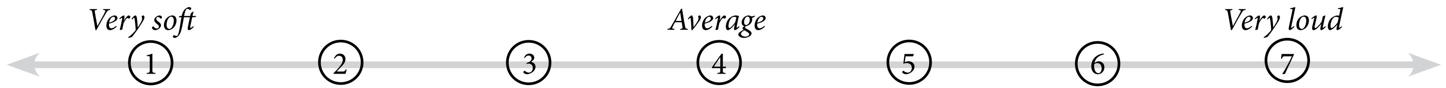
Is there anything else you would like to say about your problem?

ADDITIONAL 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. *None apply*

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

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
Heart trouble
High blood pressure
Chronic cough
Arthritis
Gout
Bleeding disorders
Asthma
Mental illness
Kidney trouble or stones
Spine problems
GERD/Acid reflux
Alcoholism
Seizures
Diabetes

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

<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
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

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

Other: ______________________________

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

M | F

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
Genetic disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
GERD	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Hearing loss	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
High cholesterol	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Kidney disease	☐ 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
Seizure disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Sickle cell anemia	☐ 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 disorder	☐ 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.*