Case History Form

Patient ____

Parent/Guardian ____

Date of Birth ____________________ Age ____________

Occupation ____

Name/Phone of physician who referred you ______________________________

Please explain the problem for which you are being seen.

____

____

____

How long have you been experiencing this/these condition(s)? ____________________

Do you smoke? ______________ If *yes*, how much? ________________________

Do you drink alcohol? _________ If *yes*, how much? ________________________

How much caffeine do you drink per day? ______________________________

How much water do you drink per day? ______________________________

List any medication(s) you are currently taking.

____

____

List any major surgeries and the approximate dates.

____

____

Have you ever been treated by an ENT (Ear, Nose & Throat) physician in the past?

____

If *yes*, for what condition(s)? ______________________________

Have you ever been treated by a speech-language pathologist? ____________________

If *yes*, explain. ______________________________

Are you a singer? _____________

Have you received formal voice training in the past? _____________

Case History Form

(continued)

Do you currently experience or have history of any of the following? (Please check the box next to any that apply.)

[ ] high blood pressure
[ ] low blood pressure
[ ] heart attack
[ ] stroke
[ ] shortness of breath
[ ] asthma
[ ] frequent bronchitis
[ ] upper respiratory conditions
(Explain ________________________)
[ ] allergies
[ ] heartburn/gastroesophageal reflux
[ ] stomach ulcers
[ ] hiatal hernia
[ ] gastrointestinal conditions
(Explain ________________________)
[ ] cancer
(Explain ________________________)
[ ] TMJ
[ ] hearing loss

[ ] dry mouth
[ ] dry throat
[ ] frequent throat clearing
[ ] chronic cough
[ ] feeling a “lump” in throat
[ ] difficulty swallowing
[ ] frequent laryngitis
[ ] frequent sore throats
[ ] voice change
[ ] throat tightness
[ ] fatigue after speaking
[ ] difficulty getting volume
[ ] loss of voice in morning
[ ] loss of voice at night

Other medical conditions not listed above:

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____

Other changes related to your throat/voice

____

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____________________________________ ____________________

Signature of Patient/Parent or Guardian Date