

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:

Other changes related to your throat/voice

Signature of Patient/Parent or Guardian

Date