THE UNIVERSITY OF ARIZONA

DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES
1131 E. Second Street
PO Box 210071
Tucson, AZ 85721-0071
Main: 520-621-1644
Fax: 520-626-1364

VOICE CASE HISTORY

Name: _____ Date: _____

Name by which you would like to be addressed: _____

Pronouns: _____Date of birth: _____ Age:_____

Members of household: _____

Referred by (include address or fax number if you would like a copy of the report sent):

_____

Occupation:_____

Do you have any hearing concerns? If yes, please describe _____

_____

Have you had any hearing evaluations with an audiologist?_____

Describe your concerns with your voice, speech, breathing, or swallowing:

_____ _____

_____ _____

_____ _____

How long have you had these problems? _____

Did they begin gradually or suddenly? _____

Have your symptoms changed since they began? (describe) _____

Were you otherwise ill when your symptoms began? _____

Were you under particular stress when your symptoms began? _____

Do you know or suspect the cause of your symptoms? _____

Have you seen an otolaryngologist (ear nose and throat physician) or speech pathologist before? If so, what were their findings? _____

What are your personal goals/expectations from today's visit?

_____

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Have you been diagnosed with or treated for any of the following? (circle)

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding tendency
- ☐ Cancer (specify)
- ☐ Diabetes
- ☐ Emphysema
- ☐ Heart problems
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ Obstructive Sleep Apnea
- ☐ Parkinson's disease
- ☐ Reflux
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other (specify)

Current Medications: Reason:

Previous surgeries (including date):

Do you use tobacco products or smoke? ___ If yes, list type and amount: _____

If no, did you use them in the past? _____

On average, how much alcohol do you drink? _____

On average, how much caffeine do you drink? _____

On average, how much water do you drink? _____

Do you have a known neurological disorder? If yes, explain: _____

Do you notice any of the following?

- ☐ Confusion
- ☐ Double vision
- ☐ Handwriting changes
- ☐ Laughing or crying for no reason
- ☐ Memory change
- ☐ Muscle spasms
- ☐ Numbness
- ☐ Shaking/tremor
- ☐ Unsteadiness
- ☐ Weakness

Do you experience any of the following?

- ☐ Heartburn
- ☐ Frequent belching
- ☐ Frequent vomiting
- ☐ Chronic throat irritation
- ☐ Sensation of a lump in your throat
- ☐ Bitter or acid taste in the morning
- ☐ Worse voice in the morning
- ☐ Pain from your throat to your ear
- ☐ Awakening at night feeling like you're choking
- ☐ Recent weigh gain