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DIAGNOSTIC CENTER
VOICE AND SWALLOWING QUESTIONNAIRE

Name: _____ Date: _____

Check any of the following symptoms that apply to you:

- □ Choking/coughing on liquids
- □ Choking/coughing on solids
- □ Food sticking in the throat
- □ Difficulty swallowing pills
- □ Painful swallowing
- □ Hoarseness
- □ Throat pain
- □ Loss of volume
- □ Breathy Voice
- □ Vocal fatigue
- □ Reduced singing range
- □ Can't sing anymore
- □ Chronic cough
- □ Frequent throat clearing
- □ Excessive phlegm
- □ Problems breathing
- □ Heartburn
- □ Postnasal drip
- □ Bitter/acid taste in mouth
- □ Feeling of something caught in the throat/ tickling sensation

When did your symptoms begin? _____ days / weeks / months / years ago

Did they begin gradually or suddenly? Gradual onset sudden onset

Did anything happen/change around the time your symptoms began (surgery, illness, change in medication, diet, stress, etc.)?
Explain:

Medical History: *Please check any medical conditions you have or have had:*

- □ Neurological Disease:
  - □ Stroke / CVA / TIA
  - □ Myasthenia Gravis
  - □ Parkinson's Disease
  - □ Multiple Sclerosis
  - □ Other:
- □ Allergies
- □ Chronic Sinusitis
- □ Respiratory Disorders
  - □ Asthma
  - □ COPD/Emphysema
  - □ Bronchitis)
  - □ Pneumonia
- □ Heart Disease
- □ High blood pressure
- □ Arthritis
- □ Gastro-intestinal Disease
  - □ Reflux disease
  - □ Hiatal hernia
  - □ Other:
- □ Surgeries to the head/neck region
- □ Injuries to the head/neck region
- □ Seizure Disorder
- □ Diabetes
- □ Kidney Disease
- □ Ulcers
- □ Cancer:_____
- □ Thyroid disease
- □ Other:

Social History:

Do you currently use any of the following tobacco products? □ Yes □ No □ Previously
□ Cigarette □ cigar □ pipe □ chewing tobacco □ vape Quantity / Frequency: _____
Do you drink alcohol currently? □ Yes □ No
How many alcoholic drinks per day/week/month? _____
How many glasses of caffeinated beverages (coffee, tea, soda) do you drink each day? _____
How many glasses of water do you drink each day? _____

Within the ***last month*****,** how did the following problems affect you**?**

	0= No Problem					***5= severe problem***
Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or postnasal drip	0	1	2	3	4	5
Difficulty swallowing foods, liquids or pills	0	1	2	3	4	5
Coughing after you ate or after lying down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5
RSI	TOTAL:			(>13)		

IF YOU HAVE VOICE PROBLEMS PLEASE FILL OUT THE FOLLOWING:

Within the ***last week*****,** how did the following problems affect you?

0= Never	***1=Almost Never***	***2= Sometimes***	***3=Almost Always***	***4= Always***

1. My voice makes it difficult for people to hear me	0	1	2	3	4
2. People have difficulty understanding me in a noisy room	0	1	2	3	4
3. People ask, “What’s wrong with your voice?”	0	1	2	3	4
4. I feel as though I have to strain to produce voice	0	1	2	3	4
5. My voice difficulties restrict my personal and social	0	1	2	3	4
6. The clarity of my voice is unpredictable	0	1	2	3	4
7. I feel left out of conversations because of my voice	0	1	2	3	4
8. My voice problem causes me to lose income	0	1	2	3	4
9. My voice problem upsets me	0	1	2	3	4
10. My voice makes me feel handicapped	0	1	2	3	4
VHI-10	TOTAL:				

IF YOU HAVE SWALLOWING PROBLEMS PLEASE FILL OUT THE FOLLOWING:

	0= No Problem				***4= severe problem***
My swallowing problem has caused me to lose weight	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals	0	1	2	3	4
Swallowing liquids takes extra effort	0	1	2	3	4
Swallowing solids takes extra effort	0	1	2	3	4
Swallowing pills takes extra effort	0	1	2	3	4
Swallowing is painful	0	1	2	3	4
The pleasure of eating is affected by my swallowing	0	1	2	3	4
When I swallow food sticks in my throat	0	1	2	3	4
I cough when I eat	0	1	2	3	4
Swallowing is stressful	0	1	2	3	4
EAT-10	Total:				

Please call with questions: 210.696.0453
Kristi DeHaan, M.S., CCC-SLP Lori J. Henkener, M.A., CCC-SLP

IF YOU HAVE VOICE PROBLEMS PLEASE FILL OUT THE FOLLOWING:

Typical Voice Uses:

I would rate my degree of talkativeness as the following: (circle response)

1	2	3	4	5	6	7
Quiet Listener			Average talker			Extremely Talkative

*Check any of the following that you **frequently** do:*

- □ Shouting / Yelling
- □ Loud Talking
- □ Long Talking
- □ Talkative Personality
- □ Playing a musical instrument
- □ Cheerleader (past or present
- □ Talking over noise
- □ Talking on the phone
- □ Singing (professionally or socially)
- □ Coaching
- □ Play sports
- □ Frequently attend sporting events
- □ Reading aloud
- □ Clear Throat
- □ Cough
- □ Loud Laughing
- □ Frequently attend musical concerts
- □ Frequently go to bars/nightclubs

Your Work:

Employment:	□ Full Time	□ Part time	□ Retired	□ Disabled	□ Unemployed
Occupation:_____					
Your work environment is:	□ stressful □ dry	□ noisy □ moist	□ quiet □ small	□ large □ warm	□ dusty □ cold
Your job requires:	□ a lot of talking	□ a lot of phone usage	□ working with chemicals	□ talking above noisy equipment	□ Singing

Your Home:

Marital Status:	□ Single	□ Married	□ Divorced	□ Separated	□ Widow
Do children live at home?	□Yes	□ No			
Your home environment is	□ stressful □ dry □ drafty	□ noisy □ moist □ dusty	□ quiet □ small	□ large □ warm	□ dusty □ cold

Additional Information about your voice and swallowing that you want to share: