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Ear, Nose & Throat Clinics of San Antonio, P.A.

DIAGNOSTIC CENTER

VOICE AND SWALLOWING QUESTIONNAIRE

Name: _____

Date: _____

Check any of the following symptoms that apply to you:

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

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:

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

Social History:

Do you currently use any of the following tobacco products? Yes No Previously

Cigarette cigar pipe chewing tobacco How much: _____

Do you drink alcohol now? Yes No

How many alcoholic drinks per day? _____

How many glasses of caffeinated beverages (coffee, tea, soda) do you drink each day? _____

How many glasses of water do you drink each day? _____

Your Work:

- Employment: Full Time Part time Retired Disabled Unemployed
- Occupation: _____
- Your work environment is: stressful noisy quiet large dusty
 dry moist small warm 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 noisy quiet large dusty
 dry moist small warm cold
 drafty dusty

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

	0= No Problem		5= severe problem			
	0	1	2	3	4	5
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
	TOTAL:		(>13)			

IF YOU HAVE SWALLOWING PROBLEMS PLEASE FILL OUT THE FOLLOWING:

	<i>0= No Problem</i>		<i>4= severe problem</i>		
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 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
	Total:				

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 Average Extremely
 Listener talker 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

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
	TOTAL:				