Stony Brook Medicine

Voice Case History Attachment

Name:_____
ENT Physician:_____
Last exam and findings:_____

Description of vocal quality:_____
Check all that apply: □ rough □ raspy □ strained □ hoarse
□ nasal □ breathy □ too soft □ too loud □ loss of voice □ voice breaks
□ pitch too high □ pitch too low □ voice becomes tired □ other

Onset/duration of vocal quality change:_____ □ Gradual □ Sudden
(Date)
Did it follow any illness/family problem/traumatic event? □ NO □ YES
Please describe:_____
Has it changed over time?_____
Is the problem: □ Consistent □ Intermittent
Does the season, time of day, weather, fatigue, mood, change your voice?_____
_____
When is your voice best/worst?_____
_____
Has the vocal quality change affected your daily life? □ NO □ YES
Vocal Hygiene: Please estimate the number of times each day the following occur?
Cups of water consumed:_____ Cough/throat clear:_____
Cups of caffeinated beverages:_____ Yell/Scream:_____
Speak above noise:_____
Do you exercise? □ NO □ YES **What type/How frequently**_____
How many ours of sleep do you get per night?_____
How is your nutrition? □ Good □ Fair □ Poor
Are you exposed to an environment with: □ Dust □ Smoke □ Chemicals
Do you sing in a choir or belong to a performing group? □ NO □ YES
Is there a humidifier in your home? □ NO □ YES
Are there any household pets? □ NO □ YES
Have you received previous therapy? □ NO □ YES **When?**_____
(Date)
Please provide the name, phone number and location where you received the therapy:_____
Have you had any professional voice training? □ NO □ YES
Please write down any additional information you feel will help us understand your voice problem:_____
_____
_____
_____