# 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 today.

______________________________________________

______________________________________________

______________________________________________

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 per week? ______________________

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? ____________

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## Case History Form, *continued*

Do you currently experience or have history of any of the following? (Please circle 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 of 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


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