Stony Brook Medicine

SPEECH-LANGUAGE PATHOLOGY
VOICE CASE HISTORY ATTACHMENT

Name: _____
Date of Birth: _____

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: (Date) _____ □ Gradual □ Sudden
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 hours of sleep do you get per night? _____
How is your nutrition? □ Good □ Fair □ Poor
Do you experience any of the following? (Check all that apply)
□ Poor morning voice quality □ Throat soreness or burning sensation not related to illness
□ Frequent throat clearing □ Coughing episodes not related to illness/swallowing
□ Increased phlegm in the throat □ Heartburn (If checked, how many times per week? ____)
□ Tastes repeating after meals □ Feeling of a lump in the throat when swallowing
□ Increased throat/mouth dryness □ Bad taste in the mouth (sour, acidic, metallic)
□ Frequent burping □ Unpredictable/variable voice quality during the day
□ Feeling of throat tightness □ Increased coughing when lying down
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: _____
_____
_____
Speech Pathologist's Notes: _____
_____