

Name	MRN	DOB	Date
Telephone H	W	M	
Pharmacy Name	Telephone		
How did you hear about us? <input type="checkbox"/> Sent by another physician (If so, please give name below.) <input type="checkbox"/> Sent by a friend <input type="checkbox"/> Internet search <input type="checkbox"/> UT reputation <input type="checkbox"/> Other (<i>Specify</i>)			
Physician #1 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	
Physician #2 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	

Important Note on Medical Records

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the neck and throat may be important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

START HERE:

What problem gives you the most trouble?

VOICE HANDICAP INDEX (VHI-10)

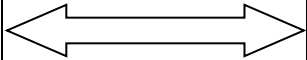
Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Please fill in the bubble of the response that indicates how frequently you have the same experience.

		Never	Almost Never	Sometimes	Almost Always	Always
F1	My voice makes it difficult for people to hear me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P2	I run out of air when I talk.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F3	People have difficulty understanding me in a noisy room.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P4	The sound of my voice varies throughout the day.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F5	My family has difficulty hearing me when I call them throughout the home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P6	I use the phone less often than I would like to.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E7	I'm tense when talking to others because of my voice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F8	I tend to avoid groups of people because of my voice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E9	People seem irritated with my voice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P10	People ask, "What's wrong with your voice?"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		0	1	2	3	4

VHI-10: _____ /40

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Reflux Symptom Index

Within the last month, how did the following problems affect you?	No problem					Severe Problem
Hoarseness or a problem with your voice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clearing your throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excess throat mucus or postnasal drip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty swallowing food, liquids, or pills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coughing after you ate or after lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathing difficulties or choking episodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Troublesome or annoying cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensations of something sticking in your throat or a lump in your throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heartburn, chest pain, indigestion, or stomach acid coming up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	0	1	2	3	4	5

RSI: ____/45

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Review of Systems

The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.

	Yes	No	Treated by another physician
General			
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fevers/chills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ears, Nose & Throat			
Hoarseness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Draining ear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daytime sleepiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tooth problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful/difficult swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ringing in the ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eyes			
Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurry vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respiratory			
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Yes	No	Treated by another physician
Gastro-intestinal			
Heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belly pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin			
Rashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Musculo-skeletal			
Muscle pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocrine			
Cold intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heat intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive thirst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hematologic			
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bruising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological			
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatric			
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Past History

Do you have any of the following medical problems?
(Please mark the circle to indicate "Yes".)

- Arthritis
- Asthma
- Bleeding disorder
- Cataracts
- Chronic fatigue syndrome
- Depression
- Diabetes
- Fibromyalgia
- Gastritis
- Glaucoma
- Hepatitis
- High blood pressure
- Heart disease
- Immunodeficiency
- Kidney disease
- Meningitis
- Migraine headache
- Mitral valve prolapse
- Peptic ulcer disease
- Seizures
- Thyroid disease
- Tuberculosis (TB)

Please list any surgery you have had:

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

- Yes
- No

(If yes, please give details.)

Please list your current medications.

Are you allergic to any medications?

- No
- Yes

Medication
Reaction

Family History

Do any of your family members have any of the following conditions?

- Allergy
- Asthma
- Bleeding disorder
- Heart disease
- Immunodeficiency
- Cancer

Social History

What is your occupation?

Have you had any recent change in your home or work environment?

Details

- Yes
- No

Have you ever smoked?

Details

- Yes-currently
- Yes- but I quit:
- No

Do you drink alcoholic beverages?

Details

- Yes
- No

Have you ever used any illicit substances?

Details

- Yes
- No.

