

Clinic For Adult Communication Disorders
Voice Case History Form

Name: _____	Date _____	
Address: _____	Email: _____	
Home Phone: _____	Message/Cell: _____	
Gender: _____	Date of birth: _____	Age: _____
Members of household: _____		
Referred by (include address or fax number if you would like a copy of the report sent): _____ _____		
Occupation: _____		
Name by which you would like to be addressed: _____		

Describe your concerns with your voice, speech, breathing, or swallowing: _____ _____ _____
How long have you had these problems? _____
Was the onset gradual or sudden? _____
Have your symptoms changed since they began? (describe) _____
Were you otherwise ill when your symptoms began? _____
Were you under particular stress when your symptoms began? _____
Do you know or suspect the cause of your symptoms? _____
Have you seen an otolaryngologist (ear nose and throat physician) or speech pathologist before? If so, what were their findings? _____

Have you been diagnosed with or treated for any of the following?

Allergies

Anemia

Arthritis

Asthma

Bleeding tendency

Cancer (specify)

Diabetes

Emphysema

Heart disease

Hiatal hernia

High blood pressure

Parkinson's disease

Reflux

Seizures

Stroke

Thyroid disease

Other (specify)

CLINIC FOR ADULT COMMUNICATION DISORDERS

UNIVERSITY OF ARIZONA

Department of Speech, Language, and Hearing Sciences

1131 E Second Street P.O. Box 210071

Tucson, AZ 85721-0071

Phone: 520-621-7070 or 520-621-1826 Fax: 520-621-9901

Allergies to medications: _____

Current Medications:

Reason:

Previous surgeries:

Do you use tobacco products? _____ If yes, list type and amount: _____

If no, did you use them in the past? _____

On average, how much alcohol do you drink? _____

On average, how much caffeine do you drink? _____

Do you have a known neurological disorder? If yes, explain: _____

Do you notice any of the following?

Confusion

Laughing or crying for no
reason

Numbness

Double vision

Shaking/tremor

Handwriting changes

Memory change

Unsteadiness

Muscle spasms

Weakness

Do you experience any of the following?

Heartburn

Frequent belching

Frequent vomiting

Chronic throat irritation

Sensation of a lump in your throat

Bitter or acid taste in the morning

Worse voice in the morning

Pain from your throat to your ear

Awakening at night feeling like you're
choking

Recent weight gain