PRETORIA VOICE CLINIC

DR. CARL SWANEPOEL
Ear, Nose and Throat Specialist
Practice no: 3003620 HPCSA no: MP0366056
Room 206 Life Groenkloof Hospital, Pretoria
Tel: +27 12 460 1284 / 066 249 1662
E-mail: doctor@drcarlswanepoel.com
Web: www.pretoriavoiceclinic.co.za

GISELLE MAARTENS
Speech Therapist & Audiologist
Practice no: 0468681 HPCSA no: STA0026646
Cell no: +27 83 387 3566

CASE HISTORY

Name: ☐ Age: ☐ Gender: ☐ Date: ☐

VOICE SYMPTOMS

1. How would you describe your voice symptoms?

	Yes	No
• Hoarse	☐	☐
• Breathy	☐	☐
• Tight	☐	☐
• Strained	☐	☐
• Weak	☐	☐
• Monotonous	☐	☐

Please explain:

2. How long have you had your present voice problem?
3. Do you know what caused your voice problem? Yes ☐ No ☐
   If yes, what?
4. Did it come on slowly or suddenly? Slowly ☐ Suddenly ☐
5. Is it getting: Worse ☐ Better ☐ Same ☐
6. Does your voice change during the day?
   If yes, explain
7. On a scale where **1= very mild** and **5 = very severe**, how would you rate your vocal symptoms? ☐
8. How often do you do the following?

	Never	Almost never	Some times	Almost always	Always
Shout or scream..........................	☐	☐	☐	☐	☐
Talk loudly....................................	☐	☐	☐	☐	☐
Talk a lot......................................	☐	☐	☐	☐	☐
Talk over noise............................	☐	☐	☐	☐	☐
Use the phone............................	☐	☐	☐	☐	☐
Sing...	☐	☐	☐	☐	☐
Cough and/or clear your throat....	☐	☐	☐	☐	☐

PHYSICAL SYMPTOMS

1. Do you have any burning, soreness, tickling, or irritation in your throat? Yes ☐ No ☐
2. Do you sometimes have the sensation of a ‘lump’ in your throat? Yes ☐ No ☐
3. Do you have any aching or tightness in your throat? Yes ☐ No ☐
4. Do you feel tension in your neck area? Yes ☐ No ☐
5. Does your voice get tired easily? Yes ☐ No ☐
6. Do you feel as if you must strain to produce voice? Yes ☐ No ☐
7. Do you feel as if you need to cough or clear your throat a lot? Yes ☐ No ☐
8. Do you have difficulty projecting your voice? Yes ☐ No ☐

MEDICAL HISTORY

1. Have you had any surgery or illnesses? Yes ☐ No ☐
   If yes, describe
2. Have you ever been intubated (breathing tube during anaesthetics)? Yes ☐ No ☐... Unsure ☐
   If yes, describe
3. Do you have any neurological conditions? Yes ☐ No ☐
   If yes, describe
4. Do you have any respiratory problems such as asthma, allergies, post-nasal drip, sinus problems or any other conditions? Yes ☐ No ☐
   If yes, describe
5. Allergies: Yes ☐ No ☐ If yes, describe
6. Do you have acid reflux or heartburn? Yes ☐ No ☐
   If yes, describe
7. Do you have any hormonal problems such as hypo- or hyperthyroidism, or any other problem?
   Yes ☐ No ☐ If yes, describe
8. Do you experience any other symptoms, such as double vision, weakness or paralysis of the face, difficulty swallowing, shaking or tremors? Yes ☐ No ☐
   If yes, describe
9. Have you injured your head or neck such as whiplash or any other injury? Yes ☐ No ☐
   If yes, describe
10. List all medication you take, including prescription, over-the-counter, vitamins, supplements, inhalants:

OCCUPATIONAL VOICE DEMANDS

1. Occupation:
2. Are you a professional voice user such as a teacher, salesperson, customer service representative or other? Yes ☐ No ☐ If yes, explain
3. Are you a professional or amateur singer? Yes ☐ No ☐
   If yes, explain
4. On a scale of 1-5 where 1 = very little and 5 = excessive, how would you characterise your daily average voice use?
5. Is there a high level of noise in your workplace? Yes ☐ No ☐
   If yes, explain
6. Are you exposed to fumes, pollutants, and other irritants in your workplace such as ammonia, chemicals, dust or others? Yes ☐ No ☐ If yes, explain

LIFESTYLE CONSIDERATIONS

1. Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes/cigars per day? ☐
2. If not, did you smoke previously? Yes ☐ No ☐ When?
3. Do you use alcohol? Yes ☐ No ☐ If yes, how much per week?
4. Do you drink caffeinated beverages such as tea, coffee, soda? Yes ☐ No ☐. how much per day? ☐
5. How much water do you drink per day?
6. Do you have a healthy diet? Yes ☐ No ☐
7. Do you have an active social life? Yes ☐ No ☐ Explain
8. Does anyone in your family or your social circle have hearing loss? Yes ☐ No ☐

FOR PROFESSIONAL VOICE USERS ONLY

1. Have you ever had training for your voice or singing voice? Yes ☐ No ☐
   If so, list teachers and years of training:
2. Do you do regular voice exercises? Yes ☐ No ☐ If yes, describe:
3. Do you warm up your voice before practice or performance? Yes ☐ No ☐
4. Do you cool down your voice after using it? Yes ☐ No ☐