

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?

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VOICE HANDICAP INDEX (VHI-10)

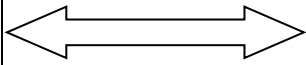
Instructions: These are statements that many people have used to describe their voices and the effects of their voices on their lives. Please fill in the bubble of the response that indicates how frequently you have the same experience.

		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	○	○	○	○	○	○	
Clearing your throat	○	○	○	○	○	○	
Excess throat mucus or postnasal drip	○	○	○	○	○	○	
Difficulty swallowing food, liquids, or pills	○	○	○	○	○	○	
Coughing after you ate or after lying down	○	○	○	○	○	○	
Breathing difficulties or choking episodes	○	○	○	○	○	○	
Troublesome or annoying cough	○	○	○	○	○	○	
Sensations of something sticking in your throat or a lump in your throat	○	○	○	○	○	○	
Heartburn, chest pain, indigestion, or stomach acid coming up	○	○	○	○	○	○	
	0	1	2	3	4	5	

RSI: ____/45