UT Physicians

UTHealth | McGovern Medical School
The University of Texas Health Science Center at Houston

New Patient Questionnaire

Texas Voice Performance Institute

Name	MRN	DOB	Date

Telephone
H W M

Pharmacy
Name Telephone

How did you hear about us?
□ Sent by another physician (If so, please give name below.)
□ Sent by a friend
□ Internet search
□ UT reputation
□ Other *(Specify)*

Physician #1 (☐ sent by this physician)
Name Fax Telephone

Address City, State Zip

Physician #2 (☐ 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.	O	O	O	O	O
P2	I run out of air when I talk.	O	O	O	O	O
F3	People have difficulty understanding me in a noisy room.	O	O	O	O	O
P4	The sound of my voice varies throughout the day.	O	O	O	O	O
F5	My family has difficulty hearing me when I call them throughout the home.	O	O	O	O	O
P6	I use the phone less often than I would like to.	O	O	O	O	O
E7	I'm tense when talking to others because of my voice.	O	O	O	O	O
F8	I tend to avoid groups of people because of my voice.	O	O	O	O	O
E9	People seem irritated with my voice.	O	O	O	O	O
P10	People ask, "What's wrong with your voice?"	O	O	O	O	O
		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	O	O	O	O	O	O
Clearing your throat	O	O	O	O	O	O
Excess throat mucus or postnasal drip	O	O	O	O	O	O
Difficulty swallowing food, liquids, or pills	O	O	O	O	O	O
Coughing after you ate or after lying down	O	O	O	O	O	O
Breathing difficulties or choking episodes	O	O	O	O	O	O
Troublesome or annoying cough	O	O	O	O	O	O
Sensations of something sticking in your throat or a lump in your throat	O	O	O	O	O	O
Heartburn, chest pain, indigestion, or stomach acid coming up	O	O	O	O	O	O
	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	O	O	O
Weight gain	O	O	O
Weight loss	O	O	O
Fevers/chills	O	O	O
Ears, Nose & Throat			
Hoarseness	O	O	O
Hearing loss	O	O	O
Draining ear	O	O	O
Vertigo	O	O	O
Loud snoring	O	O	O
Daytime sleepiness	O	O	O
Mouth sores	O	O	O
Tooth problems	O	O	O
Painful/difficult swallowing	O	O	O
Ringing in the ears	O	O	O
Eyes			
Double vision	O	O	O
Blurry vision	O	O	O
Cardiac			
Chest pain	O	O	O
Short of breath	O	O	O
Respiratory			
Wheezing	O	O	O
Cough	O	O	O

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

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Past History

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

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

Please list any surgery you have had:

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?
O Yes
O No
(If yes, please give details.)

Please list your current medications.

Are you allergic to any medications?
O No
O Yes
Medication
Reaction

Family History

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

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

Social History

What is your occupation?

Have you had any recent change in your home or work environment? Details
O Yes
O No

Have you ever smoked? Details
O Yes-currently
O Yes- but I quit:
O No

Do you drink alcoholic beverages? Details
O Yes
O No

Have you ever used any illicit substances? Details
O Yes
O No.