VOICE CLINIC
CASE HISTORY FOR SINGERS

Name ______________________ Date ______________ Sex ______________________
Age ______________________ Height _____________ Weight ________________

Voice Category: _____ soprano  _____ mezzo-soprano  _____ alto
_____ tenor  _____ baritone  _____ bass

PLEASE CHECK OR CIRCLE CORRECT ANSWERS

1. How long have you had your present voice problem? __________________________
   Who noticed it? ____________________________________________________________
   What do you think caused it? ______________________________________________
   _______________________________________________________________________

   Did it come on slowly or suddenly? (Circle one)
   Is it getting: Worse: _____ Better: _____ Staying the same ______
   Does it change with the weather? Yes _____ No _____
   Does it change with the season? Yes _____ No ______

2. Which symptoms do you have? (Please check all that apply)
   _____ Hoarseness (coarse or scratchy sound) when speaking _____ when singing _____
   _____ Fatigue (voice tires or changes quality after short time period)
       when speaking _____ when singing _____
   _____ Loudness disturbance: trouble singing softly _____ loudly _____
   _____ Loss of singing range (high _____ low _____)
   _____ Change in voice classification (e.g., voice lowered from soprano to mezzo)
   _____ Change in warm-up time (over ½ hour to warm up voice)
   _____ Breathiness when speaking _____ when singing _____
   _____ Tickling or choking sensation while speaking _____ while singing _____
   _____ Pain in throat while speaking _____ while singing _____
   _____ Tension in jaw _____ neck _____ or shoulders _____
   _____ Other (please describe)
   __________________________________________________________________________
3. Do you have an important performance soon? Yes _____ No _____
   Date(s): ____________________________

4. What is the current status of your singing career?
   Professional _____ Amateur _____ Advocation _____

5. What are your long-term career goals in singing?

6. Have you had voice training? Yes _____ No _____
   At what age did you begin? _____

7. Have there been periods of months or years without lessons in that time?
   Yes _____ No _____

8. How long have you studied with your present teacher? _____
   Teacher’s name: _________________________
   Address: _______________________________
   Telephone #: ___________________________

9. Please list previous teachers and years during which you studied with them:

10. Have you ever had training for your speaking voice? Yes _____ No _____
    Acting voice lessons? Yes _____ No _____ How many years? _______________
    Speech therapy? Yes _____ No _____ How many months? _______________
    What were goals for speech therapy? ___________________________________
        Group _____ Individual _____

11. Do you have a job in addition to singing? Yes _____ No _____
    What is this occupation? _______________________________
    Does it involve extensive voice use? Yes _____ No _____
    If yes, please describe voice use: ________________________________

12. In your performance work, in addition to singing, are you frequently required to:
    Speak? Yes _____ No _____
    Dance? Yes _____ No _____
    Other? ______________________________
13. How many years did you sing actively before beginning voice lessons initially? 

14. What types of music do you sing? (Check all that apply)
   - Classical
   - Show
   - Nightclub
   - Rock
   - Other (please specify) __________________________

15. Do you regularly sing in a sitting position (such as from behind a piano or drum set)?
   - Yes _____ No _____

16. Do you sing outdoors, or in large halls, or with orchestras? (Circle which one.)
   - Yes _____ No _____

17. If you perform with electrical instruments or outdoors, do you use monitor speakers?
   - Yes _____ No _____
   - If yes, can you hear them? Yes _____ No _____

18. Do you play a musical instrument(s)? Yes _____ No _____
   - If yes, please check all that apply:
     - keyboard (piano, organ, harpsichord, other)
     - brass
     - violin, viola
     - wind with single reed
     - cello
     - wind with double reed
     - bass
     - flute, piccolo
     - percussion
     - plucked strings
     - (guitar, harp, other)
     - bagpipe
     - accordion
     - other (please specify) __________________________

19. How often do you practice?
   - a. Scales: [daily, few times weekly, once a week, rarely, never]
     - If you practice scales, do you do them all at once, or do you divide them up over the course of the day?
     - On days when you do scales, how long do you practice them? [15, 30, 45, 60, 75, 90, 105, 120] minutes
     - On what sound do you practice scales?
b. Songs: [daily, few times weekly, once a week, rarely, never]

- How many hours per day?  
  \[\frac{1}{2}, 1, 1\frac{1}{2}, 2, 2\frac{1}{2}, 3, \text{more}\]

- Do you warm up your voice before you sing? Yes _____ No _____  
  Describe what you do:

- Do you warm down when you finish singing? Yes _____ No _____  
  Describe what you do:

- Where do you practice?

20. How much are you currently singing per day (total including practice time)?  
Rehearsal: _____ hours  
Performance: _____ hours

21. Please check all that apply to you:  
   _____ Voice worse in the morning  
   _____ Voice worse later in the day, after it has been used  
   _____ Sing performances or rehearsals in the morning  
   _____ Speak extensively (e.g., teacher, clergy, attorney, telephone work)  
   _____ Cheerleader  
   _____ Speak extensively backstage or at post-performance parties  
   _____ Choral conductor  
   _____ Frequently clear your throat  
   _____ Frequent sore throat  
   _____ Jaw joint problems  
   _____ Bitter or acid taste, or bad breath first thing in the morning  
   _____ Frequent yelling or loud talking  
   _____ Frequent whispering  
   _____ Frequent whistling  
   _____ Chronic fatigue (insomnia)  
   _____ Work around extreme dryness  
   _____ Frequent exercise (weight lifting, aerobics)  
   _____ Frequently thirsty, dehydrated  
   _____ Hoarseness first thing in the morning  
   _____ Chest cough  
   _____ Eat late at night  
   _____ Ever use antacids (How often? ____________)
_____ Under particular stress at present (personal or professional)
_____ Frequent bad breath
_____ Live, work, or perform around smoke or fumes
_____ Travelled recently: When? _____________________
Where? _____________________

Does eating any of the following foods less than 3 hours before singing cause you problems?
_____ Chocolate          _____ Coffee          _____ Alcohol
_____ Milk or ice cream  _____ Nuts          _____ Spiced foods

If yes, describe the problems:
_____ Are you currently experiencing any specific vocal technical difficulties? [trouble singing quietly, trouble singing loudly, poor pitch control, breath support problems, problems that register transitions, other] If yes, please describe:

_____ Have you had any recent problems with you singing voice prior to the onset of the problem that brought you here? [hoarseness, breathiness, fatigue, loss of range, voice breaks, pain singing, other] Describe other:

_____ Have you had any voice problems in the past that required a visit to a physician? If yes, please describe problem(s) and treatment(s): [laryngitis, nodules, polyps, hemorrhage, cancer, other]

22. Please provide you family doctor’s name, address, and telephone number:

23. Please provide your laryngologist’s name, address, and telephone number:

24. Have you had a recent cold or upper respiratory infection?
   Yes _____ No _____

25. Do you currently have a cold or upper respiratory infection?
   Yes _____ No _____

26. Have you been evaluated by an allergist? Yes _____ No _____
If yes, what allergies do you have:

If yes, give name and address of allergist:

27. Have you been exposed to any of the following chemicals frequently (or recently) at home or at work? (Check all that apply.)

_____ Carbon monoxide
_____ Arsenic
_____ Mercury
_____ Aniline dyes
_____ Insecticides
_____ Industrial solvents
_____ Lead
_____ (benzene, etc.)
_____ Stage smoke
_____ Other: (please specify)_________________

28. Smoking history:

_____ Never smoked
_____ Quit. When? ________________________________
_____ Smoked about _____ packs per day for _____ years
_____ Smoke _____ packs per day. Have smoked for _____ years
_____ Other tobacco products? (please describe.) _________________________

29. Do you work or live in a smoky environment? Yes _____ No ______

30. How much alcohol do you drink? [none, rarely, a few times per week, daily]
If daily or a few times per week, how much do you typically consume?
[1, 2, 3, 4, 5, 6, 7, 8, 9, 10, more] glasses per [day, week] of [beer, wine, or liquor].

Did you formerly drink more heavily? Yes _____ No _____

31. How many cups of coffee, tea, cola, or other caffeine-containing drinks do you drink per day? _____________

32. List other recreational drugs you use: [marijuana, cocaine, amphetamines, barbiturates, heroin, other]

33. Have you noticed any of the following? (Check all that apply)

_____ Hypersensitivity to heat or cold
_____ Excessive sweating
_____ Change in weight: [gain/lost] _____ lbs. in _____ [weeks/months]
_____ Change in skin or hair
_____ Palpitation (fluttering) of the heart
_____ Emotional lability (swings of mood)
____ Double vision
____ Numbness of the face or extremities
____ Tingling around the mouth or face
____ Blurred vision or blindness
____ Weakness or paralysis of the face
____ Clumsiness in arms or legs
____ Confusion or loss of consciousness
____ Difficulty with speech
____ Difficulty with swallowing
____ Choking on food or liquids
____ Seizures
____ Pain in the neck or shoulder
____ Shaking or tremors
____ Memory change
____ Personality change

For females:
Are you pregnant?        Yes _____ No _____
Are your menstrual periods regular?  Yes _____ No _____
Have you undergone hysterectomy? Yes _____ No _____
Were your ovaries removed? Yes _____ No _____
At what age did you reach puberty? Yes _____ No _____
Have you gone through menopause? Yes _____ No _____
If yes, when? __________________________
Are you currently going through menopause?  Yes _____ No _____

34. Brief summary of ear, nose, and throat (ENT) problems, some of which may not be related to your present complaint.
PLEASE CHECK ALL THAT APPLY
____ Hearing loss        ____ Ear pain        ____ Ear noises
____ Facial pain        ____ Dizziness        ____ Stiff neck
____ Facial paralysis    ____ Lump in neck    ____ Nasal obstruction
____ Lump in face or head ____ Nasal deformity  ____ Mouth sores
____ Trouble swallowing  ____ Excess eye skin  ____ Eye problem
____ Jaw joint problem   ____ Excess facial skin
____ Other: (please specify) ___________________________________________

35. Do you have or have you ever had:
____ Diabetes        ____ Seizures        ____ Hypoglycemia
____ Psychiatric therapy or counseling  ____ Thyroid problems  ____ Syphilis
____ Frequent bad headaches  ____ Ulcers  ____ Gonorrhea
____ Kidney disease  ____ Herpes
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<th>Condition</th>
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<td>Urinary problems</td>
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<td>Cold sores</td>
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<td>Multiple Sclerosis</td>
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<td>Other illnesses: (Please specify)</td>
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If yes to any of the above, please explain:

36. Do any blood relatives have:
   - Diabetes
   - Hypoglycemia
   - Cancer
   - Heart Disease
   - Other major medical problems such as those above. Please specify:

37. List all current medications and doses (include birth control pills and vitamins).

38. Have you ever consulted a psychologist or psychiatrist? Yes _____ No _____
    Are you currently under treatment? Yes _____ No _____

39. Have you injured your neck or head? Yes _____ No _____ If YES, Explain.

40. Describe any serious accidents related to this visit.

41. Describe serious accidents not directly related to this visit.

   - Occurred with head injury, loss of consciousness, or whiplash
   - Occurred without head injury, loss of consciousness, or whiplash

42. Are you involved in legal action involving problems with your voice?
   Yes _____ No _____
43. List names and ages of family members you live with:

44. Medication allergies
   _____ None
   _____ Novocaine
   _____ Penicillin
   _____ Iodine
   _____ Sulfa
   _____ Codeine
   _____ Tetracycline
   _____ Adhesive tape
   _____ Erythromycin
   _____ Latex gloves
   _____ Keflex/Ceclor/Ceftin
   _____ Aspirin
   _____ X-ray dyes
   _____ Other (please specify) ____________________________

45. List operations
   _____ Tonsillectomy (age _____)
   _____ Adenoidectomy (age _____)
   _____ Appendectomy (age _____)
   _____ Heart surgery (age _____)
   _____ Other (please specify) ____________________________

46. List toxic drugs or chemical to which you have been exposed:
   _____ Lead
   _____ Streptomycin, neomycin, kanamycin
   _____ Mercury
   _____ Other: (please specify)

47. Have you had x-ray treatments to your head or neck (including treatments for acne or ear problems as a child, treatments for cancer, etc.)?
   Yes _____  No _____

48. Describe serious health problems of your immediate family.