Vinod K. Anand, MD, FACS
Nose and Sinus Clinic

Patient History: Singer

How long have you had your present voice problems?
Who noticed it?
_____
Do you know what caused it?
_____
Did it come on slowly or suddenly?
_____
Is it getting worse _____ or better _____ or staying the same _____?

Which symptoms do you have? Check all that apply.
_____ Hoarseness (coarse or scratchy sound)
_____ Fatigue (voice tries or changes quality after singing for a short period of time)
_____ Volume disturbance (trouble singing softly _____ or loudly_____)
_____ Loss of range (high _____ low _____)
_____ Prolonged warm up time (over □ hour to warm up voice)
_____ Breathiness
_____ Tickling or choking sensation while singing
_____ Pain in throat while singing
_____ Other (describe)
_____

Do you have an important performance soon? Yes _____ No _____ Date(s):
_____

What is the current status of your singing career? Professional _____
Amateur_____

What are your long-term career goals in singing?

Have you had voice training? Yes _____ No _____ When did you begin?
_____

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

How long have you studied with your present teacher?
_____
Teacher□s name:
_____
Address:
_____
Telephone number:
_____

List previous teachers and years during which you studied with them:
_____
_____
_____
_____
Have you ever been trained for your speaking voice? Yes _____ No _____

How may years did you sing actively before beginning voice lessons initially?
_____

What type of music do you sing? Check all that apply.

_____ Classical
_____ Show
_____ Nightclub
_____ Rock
_____ Other
_____
_____
Do you sing outdoors or in large halls, or with orchestras? Yes _____ No _____

If you perform with electrical instruments or outdoors, do you us monitor speakers? Yes ____
No ____

How often do you practice?
Scales:
_____
_
Songs:
_____
_

How much are you singing at present (average hours per day)?
Rehearsal:
_____

Performance:
_____

Check all answers that apply to you.
_____ Voice worse in morning
_____ Voice worse later in day, after it has been used
_____ Sing performances or rehearsals in morning
_____ Speak extensively (teacher, clergyman, attorney: on telephone, during work, etc.)
_____ Cheerleader
_____ Speak extensively backstage or at post performance parties
_____ Choral conductor
_____ Frequently clear your throat
_____ Bitter or acid taste; bad breath or hoarseness first thing in morning
_____ Eat late at night
_____ Under particular stress (personal or professional) at present?
_____ Live, work, or perform around smoke or other fumes
_____ Live, work, or perform in very dry or dusty area
_____ Traveled recently; where and when
_____
Eat any of the following before singing:
_____ Chocolate
_____ Coffee
_____ Alcohol
_____ Milk or ice cream
_____ Nuts
_____ Highly spiced food
_____ Any specific vocal technical difficulties (describe)
_____ Any recent problems with your singing voice before onset of problem that brought you here
_____ Any voice problems in past that required seeing a physician (describe problem[s] and treatment[s])

Your family doctor□s name, address, and telephone:
_____

Your laryngologist□s name, address, and telephone:
_____
Recent cold? Yes _____ No _____
If yes, are symptoms still present (what symptoms?)_____

List any previous operations.
Tonsils, at what age _____

Adenoids, at what age _____
Others
_____

List any medicines you take presently and the dosage (include birth control pills and vitamins).
_____
_____
_____

Have you had radiation therapy to your head, neck, or face? Yes _____ No _____

Have you been exposed to any of the following chemicals at home or work? Check all that apply.
_____ Carbon monoxide
_____ Mercury
_____ Insecticides
_____ Lead
_____ Arsenic
_____ Aniline dyes
_____ Industrial solvents (benzene, etc.)
_____ Other (chemicals or fumes)
_____

Allergic to:
_____ Penicillin
_____ Sulfa
_____ Iodine
_____ Tetracycline
_____ Procaine (Novocain)
_____ Other (medicine, food, inhalants, etc.)

Have you been evaluated by an allergist? Yes _____ No _____ If yes, give name, address, and results
_____
__
_____
_____

How many packs of cigarettes do you smoke per day, and for how many years?
_____

If you used to smoke, how much did you smoke, for how many years, and when did you stop?
_____

_____

Does your spouse or roommate smoke? Yes _____ No _____

How much alcohol do you drink?

_____

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

_____

_____

List other drugs you use (marijuana, cocaine, etc.)

_____

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

_____ Hypersensitivity to heat or cold
_____ Excessive sweating
_____ Change in weight; weight gain _____ lb or loss _____lb in _____ weeks or _____ months
_____ Change in voice
_____ Change in skin or hair
_____ Palpitation (fluttering) of heart
_____ Emotional lability (swings of mood)
_____ Double vision
_____ Numbness of face or extremities
_____ Tingling around mouth or face
_____ Blurred vision or blindness
_____ Weakness or paralysis of face
_____ Clumsiness in arms or legs
_____ Confusion or loss of consciousness
_____ Difficulty with speech
_____ Difficulty with swallowing
_____ Seizure (epileptic fit)
_____ Pain in neck or shoulder
_____ Shaking or tremors
_____ Memory change
_____ Personality change

At what age did you reach puberty?

_____

Do you have any other health problems? Check all that apply.

_____ High blood pressure
_____ Heart problems
_____ Diabetes
_____ Arthritis

_____ Cold sores or herpes infections
_____ Tuberculosis
_____ Syphilis or gonorrhea
_____ Asthma or lung problems
_____ Kidney problems
_____ Other
_____

Have you ever consulted a psychologist or psychiatrist?

List names of spouse and children:
_____
_____
_____
_____