

**VOICE QUESTIONNAIRE:**

Describe your voice quality and throat sensations: (check all that apply)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Hoarse voice        | <input type="checkbox"/> Shaky/unsteady voice | <input type="checkbox"/> Tightness in throat  | <input type="checkbox"/> Throat irritation        |
| <input type="checkbox"/> Breathy voice       | <input type="checkbox"/> Voice breaks         | <input type="checkbox"/> Lump in throat       | <input type="checkbox"/> Dry throat               |
| <input type="checkbox"/> Gravelly voice      | <input type="checkbox"/> Change in pitch      | <input type="checkbox"/> Mucus in throat      | <input type="checkbox"/> Frequent coughing        |
| <input type="checkbox"/> Raspy voice         | <input type="checkbox"/> Change in volume     | <input type="checkbox"/> Pain in throat       | <input type="checkbox"/> Frequent throat-clearing |
| <input type="checkbox"/> Scratchy voice      | <input type="checkbox"/> Straining to speak   | <input type="checkbox"/> Pain with swallowing |   |
| <input type="checkbox"/> Total loss of voice | <input type="checkbox"/> Voice tires easily   | <input type="checkbox"/> Tickle in throat     | <input type="checkbox"/> <b>NORMAL</b>            |

Other: \_\_\_\_\_

Rate your voice quality on a scale of 0-10:

(0 = no voice at all, 10 = completely normal voice)

0	1	2	3	4	5	6	7	8	9	10
no voice										normal
(whisper)										(100%)

When did you first notice the problem?

\_\_\_\_\_

What, if anything, do you associate with the start of your problem?

\_\_\_\_\_

Over time, how has the problem changed?

SAME          BETTER          WORSE

How frequently do the symptoms occur?

CONSTANTLY          INTERMITTENTLY

How do the symptoms vary? Circle all which apply:

ALWAYS THE SAME	WORSE IN AM	WORSE AFTER HEAVY VOICE USE
UNPREDICTABLE	WORSE IN PM	WORSE WITH STRESS

Have you ever had a voice problem before?

NO      YES (describe):

Have you ever had voice therapy?

NO      YES (when/where):

Do you participate in the performing arts (singing, acting, etc.)?

NO      YES (describe):

**Vocal Health**

How many caffeinated beverages do you drink per day (coffee, tea, sodas, etc)?

0   1   2   3   4   5   6   7   8   &gt;8

 How many 8-ounce glasses of **water** do you drink per day?

0   1   2   3   4   5   6   7   8   &gt;8

Do you drink alcohol?

 NO      YES      QUIT  
 If yes, how often?          # of servings:

Do you smoke?

 NO      YES      QUIT  
 If yes, # of packs per day:          # of years:

Are you taking any over-the-counter remedies such as throat lozenges or sprays? List:

\_\_\_\_\_

How much do you use your voice?

LIMITED          AVERAGE          EXTENSIVE