


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

# Voice Case History Form

Name _____ Date _____

Date-of-Birth _____ Age _____

Address _____

_____

Phone _____ Alternate Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address _____

Occupation/Former Occupation _____ Employer _____

Highest Level of Education Completed _____

Name of Spouse or Nearest Relative _____

Native Language _____ Primary Language _____

Physician's Name _____ Phone _____

Referred by _____

Person Completing this Form _____ Relationship _____

**CONCERN**

What is your main concern?

_____

_____

When did you first notice a problem with your voice?

_____

_____

Describe the course of the problem, any treatment that you have had, where, and who treated you

_____

_____

Does your voice get better, worse, or stay the same? _____

When is it better? _____

When is it worse? _____

Describe any feelings you have in your throat (such as tickle, lump, pain, difficulty swallowing, strain, fatigue, etc.)

_____

_____

Factors related to lifestyle/environment (Check all that apply):

_____ Choir/singing
_____ Drama/acting
_____ Debate
_____ Work in a noisy environment
_____ Sports
_____ Poor sleeping habits
_____ Poor nutrition/eating habits
_____ Teaching
_____ Other, explain:_____

**MEDICAL HISTORY**

Check pertinent conditions:

_____ Allergies
_____ Respiratory Problems
_____ Asthma
_____ Neurological Problems
_____ Other health conditions, explain _____

Have you had any of the following?

_____ Surgery on your throat/larynx? When? _____
_____ Heart Surgery? When? _____
_____ Chest Surgery? When? _____
_____ Thyroid Surgery? When? _____
_____ Stroke? When? _____
_____ Injury to the neck? When? _____
_____ Chemical or Inhalation Exposure? When? _____
_____ Other, explain _____

Medications currently or recently taken

_____

_____

Family history of voice and/or speech problems

_____

_____