



PROVINCIAL VOICE CARE RESOURCE PROGRAM

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PLEASE PROVIDE THE FOLLOWING INFORMATION AS ACCURATELY AND COMPLETELY AS POSSIBLE:

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M or F

Tel: Res: _____ Work/Cell: _____ Email: _____

OCCUPATION(S) (list all **current** & seasonal occupations) # YEARS Full-Time or Part-Time (specify %)

1) _____ - _____

2) _____ - _____

3) _____ - _____

REASON FOR VISIT: Describe Symptoms in order of Importance:

How Long?

Symptom #1: _____;

Symptom #2: _____;

Symptom #3: _____;

Other Concerns: _____

Work days missed due to throat/voice problems: _____ When? _____

MEDICATIONS AND DOSAGE: _____

ALLERGIES, INCLUDING DRUG ALLERGIES: _____

SURGERIES, SERIOUS ILLNESSES, INJURIES AND HOSPITALIZATIONS (descriptions and dates):

(Please turn over)

FAMILY HISTORY OF SERIOUS ILLNESSES, AND SPEECH AND HEARING PROBLEMS:

PLEASE ESTIMATE YOUR **DAILY SERVINGS** OF THE FOLLOWING:

_____ Water _____ Herbal tea, Juice (non-caffeinated/non-alcoholic beverages)
_____ Caffeinated Coffee _____ Caffeinated Tea _____ Caffeinated Soft Drinks
_____ Chocolate _____ Beer _____ Wine _____ Spirits

Do you smoke? **Yes** or **No** If **no**, are you a former smoker? **Yes** or **No**

If you are a **former** smoker, when did you stop smoking? _____

If **you currently smoke** please indicate your daily consumption:

_____ Cigarettes _____ Cigars _____ Pipe _____ Other
(medicinal or recreational)

PLEASE CHECK IF YOU HAVE EVER HAD:

___ Anxiety Disorder	___ Headaches (Chronic)	___ Neurological Disease
___ Asthma	___ Head Injury	___ Post-Nasal Drip
___ Arthritis	___ Hearing Problems	___ Psychiatric Disorder
___ Breathing Problems	___ Heartburn	___ Severe Snoring
___ Chronic Fatigue	___ Hiatal Hernia	___ Sleep Disorder
___ Chronic Cough/Choking	___ Hoarseness	___ Swallowing Problem
___ Depression	___ Irritable Bladder	___ Tinnitus
___ Diabetes	___ Irritable Bowel	___ Throat Clearing
___ Dizziness	___ Lump in Throat Sensation	___ Thyroid Problem
___ Dramatic Weight Gain / Loss	___ Multiple Chemical Sensitivity	___ TMJ Disorder
___ Eating / Digestive Disorder	___ Nose or Sinus Problems	___ Tremor
___ Fibromyalgia	___ Neck or Back Injury	___ Total Voice Loss

When was your last hearing test? _____ Result? _____

Does your voice change with your emotions? (describe): _____

Do you use your voice in your occupation, or in performance? (describe): _____

Do your symptoms change with the amount and type of voice use? (describe): _____
