Bastian Voice Institute
for voice, swallowing & airway disorders

3010 Highland Parkway, Suite 250
Downers Grove, IL 60515
Phone: 630-724-1100

NEW PATIENT QUESTIONNAIRE

Name ______________________________ Date ____________

Date of birth ____________ Age ______ Occupation(s) ____________________

Primary care physician (*name, address*) ______________________________

Who referred you to this office?

☐ **Physician** (*name, address*) ______________________________
☐ Friend ☐ Voice teacher ☐ Speech pathologist
☐ Internet ☐ Television ☐ Newspaper
☐ Hospital ☐ Insurance company ☐ Professional organization
☐ Other ______________________________

Please list anyone to receive a report of today's visit (if any) **in addition** to physician above:

1. Name ____________________ Phone ____________
   Address ____________________ City/State ____________
2. Name ____________________ Phone ____________
   Address ____________________ City/State ____________

PROBLEM OVERVIEW

What is the primary problem you need addressed? ______________________________

____

When and how did it begin? ______________________________

Symptoms (limitations): What **can't** you do that you should be able to? ____________

____

Symptoms (aberrations): What does happen that **shouldn't**? ____________

____

Previous diagnosis and treatment elsewhere: ______________________________

____

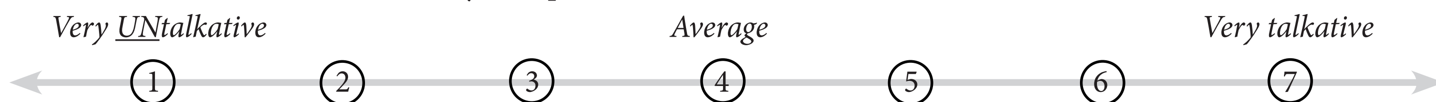
Circle the number on the scale below which indicates how **severe** your problem seems to you.

How **motivated** would you say you are to solve this problem?

ADDITIONAL VOCAL HISTORY

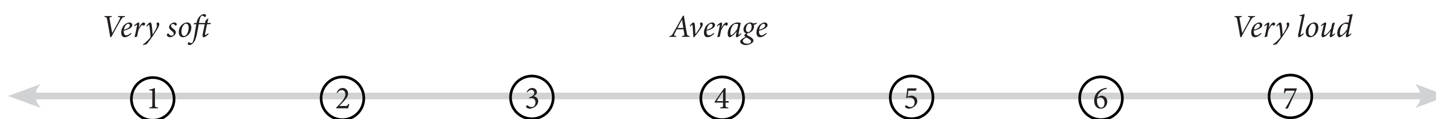
Please circle the number below which corresponds to how **talkative** you believe you are, *by nature* (not by occupation or other circumstance).

Very UNtalkative *Average* *Very talkative*



How would you describe the **loudness** of your conversational voice?

Very soft *Average* *Very loud*



Vocal commitments: ____

Any voice training? If so, number of years: _____ Teacher(s): ______________________

MEDICAL HISTORY

Check all that apply. ☐ *None apply*

☐ Heart attack	☐ Diabetes	☐ Lung disease	☐ Liver trouble
☐ Heart failure	☐ Stroke	☐ HIV	☐ Hepatitis
☐ High blood pressure	☐ Seizures	☐ AIDS	☐ Thyroid
☐ Osteoarthritis	☐ Mental illness	☐ Tuberculosis	☐ Bleeding
☐ Rheumatoid arthritis	☐ Kidney stones	☐ Asthma	☐ Anemia
☐ Kidney failure	☐ Blood clot in leg	☐ Blood clot in lung	☐ Cancer
☐ Gout	☐ Osteoporosis	☐ Alcoholism	☐ Stomach ulcers
☐ **GERD**	☐ Serious injury (*explain*)		

☐ Other: ____

SURGICAL HISTORY

List previous procedures you have had, if any. ☐ *None*

Operation	Surgeon	Date

MEDICATIONS

List any medications you take, if any. ☐ *None*

____

____

Are there any prescription medications you have **allergies** or **adverse reactions** to?
☐ No, none
☐ Yes (*please list*): ______________________________

Do you have a living will?
☐ No
☐ Yes

SOCIAL HISTORY

Tobacco use:
☐ **Never**

<u>**If current**</u>:
☐ Cigarettes, __ packs/day for __ years
☐ Cigar ☐ Chew
☐ Pipe ☐ Vape
☐ Marijuana

<u>**If former**</u>:
☐ Cigarettes, __ packs/day for __ years
☐ Cigar ☐ Chew
☐ Pipe ☐ Vape
☐ Marijuana
Quit when? ____________

Alcohol use:

☐ None at all
☐ 1–3 beverages per week
☐ 4–8 beverages per week
☐ 8+ beverages per week

Other:

Caffeinated beverages per day: ____
Total fluids (in cups) per day: ____

REVIEW OF SYSTEMS

Check all that apply. ☐ *None apply*

☐ Reading glasses
☐ Change of vision
☐ Loss of hearing
☐ Ear pain
☐ Toothache
☐ Nosebleeds
☐ Morning cough
☐ Shortness of breath
☐ Frequent belching
☐ Seizures
☐ Abnormal heartbeat
☐ Swollen ankles
☐ Calf cramps with walking
☐ Poor appetite
☐ Difficulty urinating
☐ Nausea/vomiting
☐ Stomach pain
☐ Ulcers
☐ Heart or chest pain
☐ Frequent constipation
☐ Hemorrhoids
☐ Frequent urination
☐ Burning on urination
☐ Difficulty swallowing
☐ Recent weight change
☐ Frequent headaches
☐ Blackouts
☐ Heartburn
☐ Hot or cold
☐ Snoring, apnea
☐ Nervous
☐ Chronic pain
☐ Gum trouble
☐ Frequent spotting
☐ Irregular periods
☐ Fever or chills
☐ Skin rash
☐ Other: ______________________________

FAMILY HEALTH HISTORY

Please complete the following family history information for your records by circling each blood relative who is affected by the following:

☐ Check here if none apply

☐ Adopted, no known biological family health history

Condition							M | F
Allergies	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Asthma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Autoimmune disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Blood disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
* Type/age of onset:							
Cardiovascular disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Chronic otitis media	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Coronary artery disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Deafness	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Depression	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Developmental delay	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Genetic disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
GERD	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Hearing loss	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
High cholesterol	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Hypertension	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Kidney disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Migraines	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Obesity	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Osteosclerosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Seizure disorder	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Sickle cell anemia	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Sleep apnea	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Thyroid disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin
Other (please specify):							
Deceased	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son	☐ Twin

Thank you for filling out this questionnaire!