BASTIAN VOICE INSTITUTE
for voice, swallowing & airway disorders

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Phone: 630-724-1100

NEW PATIENT QUESTIONNAIRE: INABILITY TO BELCH

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

When and how did you become aware of your inability to belch?

_____

_____

Abdominal bloating? Explain.

_____

_____

What about gurgling noises? Describe.

_____

_____

Does it cause pain? If so, describe the nature, severity, location.

_____

_____

PROBLEM OVERVIEW (CONTINUED)

What is the main problem it causes?

Excessive flatulence?

Do you think your ability to vomit is different from other people? If so, describe.

To your knowledge, were you hard to burp as an infant? Were you gassy or colicky?

Do you experience heartburn or acid belching?

How does this problem affect your lifestyle? What adjustments have you made to your social life?

Previous diagnosis and treatment elsewhere:

Click on 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?

Is there anything else you would like to say about your problem?

ADDITIONAL 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 loud*

1 2 3 4 5 6 7

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

Very soft — *Average* — *Very loud*

1 2 3 4 5 6 7

Vocal commitments: _____

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

MEDICAL HISTORY

Check all that apply.

- ☐ *None apply*
- ☐ Heart attack
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Kidney failure
- ☐ Gout
- ☐ GERD/Acid reflux
- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Mental illness
- ☐ Kidney stones
- ☐ Blood clot in leg
- ☐ Osteoporosis
- ☐ Allergies
- ☐ Lung disease
- ☐ HIV
- ☐ AIDS
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Blood clot in lung
- ☐ Alcoholism
- ☐ Liver trouble
- ☐ Hepatitis
- ☐ Thyroid
- ☐ Bleeding
- ☐ Anemia
- ☐ Cancer
- ☐ Stomach ulcers
- ☐ Serious injury (*explain*): _____
- ☐ Other: _____

SURGICAL HISTORY

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

Operation	Surgeon	Date

FAMILY HISTORY

Check all that apply.

- ☐ *None apply*
- ☐ Stroke
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Chronic cough
- ☐ Neurological disorder: _____
- ☐ Arthritis
- ☐ Gout
- ☐ Bleeding disorders
- ☐ Asthma
- ☐ Mental illness
- ☐ Kidney trouble or stones
- ☐ Spine problems
- ☐ GERD/Acid reflux
- ☐ Psychiatric disorder: _____
- ☐ Alcoholism
- ☐ Seizures
- ☐ Diabetes
- ☐ Cancer: _____
- ☐ Other: _____

MEDICATIONS

List 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
☐ Gum trouble
☐ Nosebleeds
☐ Frequent headaches
☐ Dizziness
☐ Blackouts
☐ Seizures
☐ Numbness or tingling

☐ Abnormal heartbeat
☐ Heart or chest pain
☐ Chronic pain
☐ Arthritis
☐ Calf cramps with walking
☐ Swollen ankles
☐ Cold intolerance
☐ Recent weight change
☐ Poor appetite
☐ Difficulty swallowing
☐ Stomach pain
☐ Other: _____

☐ Nausea/vomiting
☐ Fever or chills
☐ Frequent urination
☐ Burning on urination
☐ Difficulty urinating
☐ Frequent constipation
☐ Hemorrhoids
☐ Skin rash
☐ Hot or cold
☐ Irregular periods
☐ Frequent spotting

☐ Nervous
☐ Ulcers
☐ Heartburn
☐ Acid belching
☐ Morning sore throat
☐ Morning cough
☐ Morning mucus
☐ Hoarseness
☐ Breathing problem
☐ Snoring
☐ Breath-holding at night

FAMILY HISTORY

Please complete the following family history information for your records by indicating each blood relative (**Mother, Father, Sister, Brother, Daughter, Son, Twin**) who is affected by the following:

☐ Check here if none apply

☐ Adopted, no known biological family health history

☐ 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 disorder	☐ 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. When you are finished, please either save and email it back to us (**again, only possible if you are using version XI of Adobe Reader**) or else print it out at home and bring it when you come in.*