

NEW PATIENT QUESTIONNAIRE: INABILITY TO BELCH

Before you fill out this form: If you will wish to save and email this form to us once completed, be sure that you are using Adobe Reader XI. Go to "Help" → "About Adobe Reader ___" (Windows) or "Adobe Reader" → "About Reader" (Mac) to check your version. If you use Adobe Reader X or earlier to fill this out and email it to us, we will receive a blank form! Thus, if you have version X or earlier of Adobe Reader, you must either update to version XI before filling out and saving this form, or else you may fill out the form and print it out, without saving it electronically.

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.

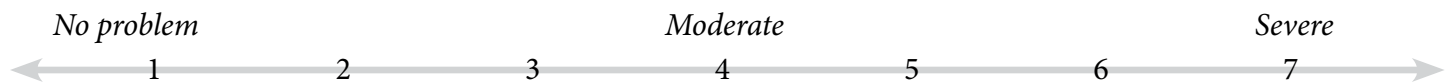
To your knowledge, were you hard to burp as an infant? Were you gassy or colicky?

Do you experience heartburn or acid belching?

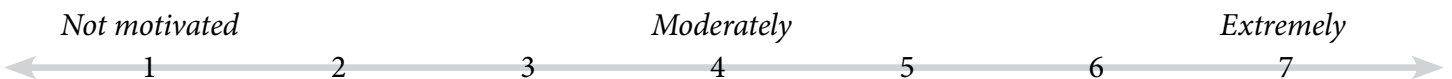
How does this problem affect your lifestyle? What adjustments have you made to your social life?

Previous diagnosis and treatment elsewhere:

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



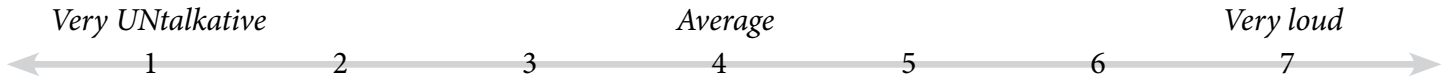
How **motivated** would you say you are to solve this problem?



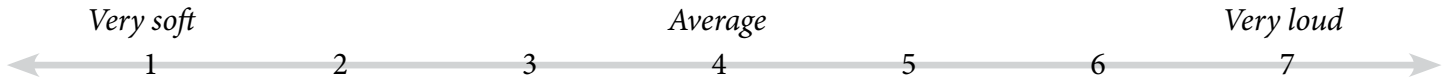
Is there anything else you would like to say about your problem?

ADDITIONAL HISTORY

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



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



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/Acid reflux | Allergies | | |

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 | Arthritis | Mental illness | Alcoholism |
| Heart trouble | Gout | Kidney trouble or stones | Seizures |
| High blood pressure | Bleeding disorders | Spine problems | Diabetes |
| Chronic cough | Asthma | GERD/Acid reflux | |

Neurological disorder: _____ Psychiatric disorder: _____

Cancer: _____

Other: _____

MEDICATIONS

List medications you take, if any.

None

Do you have any **allergies** or **adverse reactions** to medications?

No, none

Yes (please list): _____

Do you have a living will?

No

Yes

SOCIAL HISTORY

Tobacco use:

Never

If current:

Cigarettes, __ packs/day
for __ years

Cigar Chew

Pipe

If former:

Cigarettes, __ packs/day
for __ years

Cigar Chew

Pipe

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.

Reading glasses

Change of vision

Loss of hearing

Ear pain

Toothache

Gum trouble

Nosebleeds

Frequent headaches

Dizziness

Blackouts

Seizures

Numbness or tingling

None apply

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

Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Autoimmune disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Blood disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin

* Type/age of onset:

Cardiovascular disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Chronic otitis media	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Coronary artery disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Deafness	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Depression	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Developmental delay	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
High cholesterol	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Genetic disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
GERD	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Hearing disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Hypertension	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Migraines	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Obesity	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Osteosclerosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Renal disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Seizure disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Sickle cell disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Sleep apnea	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Thyroid disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
Other (please specify):							

Deceased	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Twin
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*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.*