NYU School of Medicine
NYU LANGONE MEDICAL CENTER

NYU Voice CENTER

Milan R. Amin, M.D.
Director

Ryan C. Branski, Ph.D.
Associate Director

What medical complaint(s) brought you here today? _____

How did you hear about the NYU Voice Center? _____

How long have you had this/these problem(s)? _____

Have you received treatment for this/these problem(s)? ☐ Yes ☐ No, If so, what?_____

When are your symptoms worse? ☐ Morning ☐ Night ☐ With meals ☐ No particular time ☐ Other _____

How severely are you affected by this/these problem(s)? ☐ No problem ☐ Mild annoyance ☐ Severe ☐ Occasional problems

Do these problems limit professional and/or social activities ☐ Yes ☐ No

What is your profession? _____

Do you sing? ☐ Yes ☐ No

How important is your voice on a daily basis? ☐ Critical ☐ Very Important ☐ Moderately Important ☐ Not so Important

Do you have problems with any of the following? Please check those that apply

GENERAL -	☐ NO ☐ Fever ☐ Weight Change ☐ Fatigue
EYES -	☐ NO ☐ Visual Loss ☐ Glaucoma ☐ Cataracts ☐ Itchy Eyes ☐ Tearing ☐ Blurred Vision
EARS -	☐ NO ☐ Vertigo ☐ Dizziness ☐ Ringing Noises ☐ Hearing Loss ☐ Hearing Aid ☐ Infection
NOSE -	☐ NO ☐ Discharge *__Clear__Colored__thick__thin* ☐ Post Nasal Drip ☐ Obstruction ☐ Bleeding ☐ Sneezing
MOUTH-	☐ NO ☐ Lumps ☐ Dental Problems ☐ Tonsillitis ☐ Mouth Sores
THROAT-	☐ NO ☐ Hoarseness ☐ Voice Change ☐ Problems Swallowing ☐ Pain
NECK -	☐ NO ☐ Pain ☐ Lumps ☐ Thyroid Nodules ☐ Swollen Glands
SKIN -	☐ NO ☐ Breast Lumps ☐ Psoriasis ☐ Skin Growths ☐ Rash ☐ Itching
LUNGS -	☐ NO ☐ Wheezing ☐ Asthma ☐ COPD ☐ Bronchitis ☐ Emphysema ☐ Coughing up Blood ☐ Chronic Cough ☐ Pneumonia ☐ Positive TB Test ☐ Shortness of Breath
SLEEPING -	☐ NO ☐ Snoring ☐ Apnea ☐ Insomnia ☐ Waking Up Tired ☐ Daytime Tiredness
HEART -	☐ NO ☐ High Blood Pressure ☐ Coronary Artery Disease ☐ Myocardial Infarction ☐Chest Pain ☐ Mitral Valve Prolapse ☐ Congestive Heart Failure ☐ Heart Valve Disease ☐ Angina ☐ Murmurs ☐ Rheumatic Fever
GASTROINTESTINAL -	☐ NO ☐ Hiatal Hernia ☐ Heartburn ☐ Reflux ☐ Rectal Bleeding ☐ Ulcers ☐ Hepatitis Type___ ☐ Jaundice ☐ Nausia ☐ Vomiting Colitis
GENITO-URINARY -	☐ NO ☐ Frequent Urination ☐ Pain ☐ Discharge ☐ Incontinence ☐ Bloody Urine Men: ☐ Prostate Problems ☐ Hernias Women: ☐ Abnormal Periods ☐ Menopause ☐ Are You Pregnant? ☐ Yes ☐ No
MUSCLE/JOINTS -	☐ NO ☐ Muscle Pain ☐ Back Pain ☐ Joint Pain ☐ Arthritis ☐ Lupus ☐ Gout
NEUROLOGICAL -	☐ NO ☐ Headaches ☐ Migraine Headaches ☐ Imbalance ☐ Alzheimer's Disease ☐ Tremors ☐ Loss of Consciousness ☐ Parkinson's Disease ☐ Head Trauma ☐ Fainting ☐ Seizures ☐TLA's ☐ Stroke
PSYCHIATRIC -	☐ NO ☐ Nervousness ☐ Anxiety ☐ Depression ☐ Mood Swings
ENDOCRINE -	☐ NO ☐ Thyroid Disease ☐ Diabetes ☐ Glandular/Hormonal Problems
HEMATLOGIC -	☐ NO ☐ Slow to Heal After Cuts ☐ Easy Bruising or Bleeding ☐ Immunocompromised Status ☐ Transfusion ☐ Phlebitis ☐ Anemia

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Please list any medical conditions that you may have: Ex: (HIV, AIDS, Cancer) _____

_____

_____

Have you ever had surgery? ☐ Yes ☐ No If so, did it involve your throat, neck, or chest? ☐ Yes ☐ No
Please list all surgeries: _____

_____

Please list any disorders/diseases that run in your family _____

_____

Do you Smoke? ☐ Yes ☐ No If so, how many packs/day?____ How Long? _____
Have you ever smoked? ☐ Yes ☐ No Quit Date: _____

Do you drink Alcohol? ☐ Never ☐ Rarely ☐ Several times/month ☐ Several times/week ☐ Daily
Any Drug Use? ☐ Yes ☐ No List substance/s: _____
Other pertinent information (*please indicate below):*

☐ I agree to allow NYU Voice Center to contact me via email with practice updates, matters related to scheduling, and changes in contact information