Voice Center
New patient medical history form
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Name_____ Date_____

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

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):*