

Under what circumstances is this problem most troublesome? _____

How long have you had the problem? When was it first noticed? _____

Did it develop suddenly? Slowly? Explain. _____

What do you regard as the cause of the problem? _____

Family and Medical History

Do any other members of your family have a voice, speech, or hearing problem? Explain. _____

Names, relationship and age of others living in your home _____

Please check any condition you now have or have had in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Inhalant Allergies | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Medication Allergies | <input type="checkbox"/> Voice Problems | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Slurred Speech | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stuttering | <input type="checkbox"/> Chronic Indigestion |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Bowel and Bladder Disease | |
| <input type="checkbox"/> Headaches | | |
| <input type="checkbox"/> Hernia | | |

Are you taking any medications? _____

Have you ever had surgery? _____ Date and Results: _____

Do you smoke? _____ How much? _____ For how long? _____

Describe your present health status: _____

Previous Evaluations or Therapy

Have you previously had evaluations for speech, voice, or hearing disorder? If so, when and by whom? _____

Have you previously been enrolled in speech therapy? If so, describe the nature and result of the therapy _____

Please note any additional information you feel is pertinent to your case. _____

What would you like to learn from this evaluation? _____

This form was completed by: _____

Relationship to patient: _____