

NEW PATIENT INFORMATION -- VOICE INSTITUTE OF NEW YORK – Tel (212) 463-8014, Fax (646) 607-9196

Name _____ DOB _____ Age _____ Today's date _____

Address _____

Home Telephone (Area Code) _____ Work Telephone (Area Code) _____

Gender: Male Female Race: Caucasian African-American Asian Hispanic Other _____

Employer _____

Spouse's Name _____ Daytime Telephone: _____

Person to contact in case of an emergency (*Other than spouse*) _____

Daytime phone _____ Relationship _____

Primary Insurance Co.: _____ Secondary Insurance Co. _____

Policy Holder's Name. _____ Policy Holder's Name _____

Policy # (Include Group/Plan) _____ Policy # (Include Group/Plan) _____

Please list name, address and phone number of your referring physician, family physician, and any other health care professional with whom you would like us to correspond, that is, send reports:

Referring Physician _____ Family Physician _____

Other Healthcare Provider _____ Other Healthcare Provider _____

I consent to the release of my medical information to the physicians named above and to other health care providers participating in my care.

I do not wish to have any of my medical information or records shared with other health care providers.

Signature _____

How did you hear about the Voice Institute of New York? _____

What is your occupation? _____

What is your marital status? Single Married Widowed

Do you have a parent or sibling with any of the following problems?

Allergies Yes No Heart Disease Yes No Cancer Yes No Hearing Loss Yes No

Please check or list any medical problems you currently experience

Hypertension Yes No Diabetes Yes No Heart Disease Yes No Lung Disease Yes No Other Yes No

Medications: Are you on any medications? No Yes If yes, what medications (and dosage) are you on? (Include non-prescription medications.) _____

Do you use any heartburn or anti-reflux medications? No Yes

If yes, what medications are you on? _____

List any drug allergies _____

Please list all prior surgery you have had and year performed _____

Review of Systems: Please Check Any Symptoms You Currently Experience

Throat and Voice	<input type="checkbox"/> None <input type="checkbox"/> Hoarseness <input type="checkbox"/> Laryngitis <input type="checkbox"/> Change in voice <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sore throat <input type="checkbox"/> Feeling of something in your throat
Constitutional	<input type="checkbox"/> None <input type="checkbox"/> Fatigue <input type="checkbox"/> Change in weight <input type="checkbox"/> Fever <input type="checkbox"/> Poor appetite <input type="checkbox"/> Headaches
Ears	<input type="checkbox"/> None <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Dizziness <input type="checkbox"/> Balance
Nose/Sinuses	<input type="checkbox"/> None <input type="checkbox"/> Congestion <input type="checkbox"/> Runny nose <input type="checkbox"/> Facial pain or pressure <input type="checkbox"/> Loud snoring
Mouth and Neck	<input type="checkbox"/> None <input type="checkbox"/> Pain in neck <input type="checkbox"/> Lumps in neck
Eyes	<input type="checkbox"/> None <input type="checkbox"/> Problems with vision <input type="checkbox"/> Double vision
Skin	<input type="checkbox"/> None <input type="checkbox"/> Rash <input type="checkbox"/> Change in moles
Respiratory	<input type="checkbox"/> None <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up blood
Cardiovascular	<input type="checkbox"/> None <input type="checkbox"/> Chest Pain <input type="checkbox"/> Swelling in legs
Hematologic	<input type="checkbox"/> None <input type="checkbox"/> Unusual bleeding <input type="checkbox"/> Swollen lymph nodes
Gastrointestinal	<input type="checkbox"/> None <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain
Breasts	<input type="checkbox"/> None <input type="checkbox"/> Lumps <input type="checkbox"/> Discharge <input type="checkbox"/> Tenderness
Urinary/Reproductive	<input type="checkbox"/> None <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Inability to void <input type="checkbox"/> Sexually transmitted disease(s)
Musculoskeletal	<input type="checkbox"/> None <input type="checkbox"/> Pain in neck <input type="checkbox"/> Painful joints <input type="checkbox"/> Weakness
Endocrine/Metabolic	<input type="checkbox"/> None <input type="checkbox"/> Heat or Cold intolerance <input type="checkbox"/> Hair change <input type="checkbox"/> Excessive thirst
Neurological	<input type="checkbox"/> None <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremor <input type="checkbox"/> Seizures <input type="checkbox"/> Blackouts <input type="checkbox"/> Difficulty walking
Psychiatric/Emotional	<input type="checkbox"/> None <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alcohol or drug abuse

Do you smoke? No Yes If yes, for how many years? _____

How much do you smoke?

Less than 1 pack/day 1 pack/day or more 2 packs/day or more More than 3 packs/ day

Have you ever smoked? No Yes

If yes, how many years did you smoke? _____ How many years ago did you quit smoking? _____

Do you use any other kind of tobacco? No Yes

If yes, what kind? Chewing tobacco Snuff/dip Cigars Pipe Other _____

Do you drink alcohol?: Never Rarely Several times a month Several times a week Daily

If you drink, what do you drink? Beer Wine Liquor

Are you on a salt-restricted diet? No Yes

[Females Only] Date of last period _____ Do you think you might be pregnant now? No Yes

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

Have you received treatment for this (these) problem(s)? No Yes If yes, how long? _____

Please answer each question below even if your answer is No.

Check the appropriate response.

1. How long have you experienced the medical problem that brought you here today?

- Past Month Past Six Months Past Year Last 1 – 5 Years More than 5 years

2. During the time that you have experienced this medical problem, how severely has it affected the quality of your life?

- No Problem Mild Annoyance Significant Problems Occasionally
 Limits Professional and/or Social Activities Disabling

Circle the appropriate response.

Within the last MONTH, how did the following problems affect you?	0 = No Problem			5 = Severe Problem			
Speaking took extra effort	0	1	2	3	4	5	
Throat discomfort or pain after using your voice	0	1	2	3	4	5	
Vocal fatigue (voice weakened as you talked)	0	1	2	3	4	5	GCI
Voice cracks or sounds different	0	1	2	3	4	5	

Circle the appropriate response.

Within the last MONTH, how did the following problems affect you?	0 = No Problem			5 = Severe Problem			
Hoarseness or a problem with your voice	0	1	2	3	4	5	
Clearing your throat	0	1	2	3	4	5	
Excess throat mucous or postnasal drip	0	1	2	3	4	5	
Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5	
Coughing after you ate or after lying down	0	1	2	3	4	5	
Breathing difficulties or choking episodes	0	1	2	3	4	5	
Troublesome or annoying cough	0	1	2	3	4	5	
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5	RSI
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5	

Circle the appropriate response.

Within the last MONTH, how often	0 = Never			5 = All the Time			
Did you have to clear your throat before speaking or talking on the telephone?	0	1	2	3	4	5	
Did throat discomfort or pain interfere with your normal work or daily activities?	0	1	2	3	4	5	
Did you limit the amount of time you spent talking to other people due to problems with your voice?	0	1	2	3	4	5	
Did coughing interfere with your work or other activities?	0	1	2	3	4	5	
Did breathing problems interfere with your work or other activities?	0	1	2	3	4	5	
Did you have a problem swallowing food, liquids, or pills?	0	1	2	3	4	5	

STOP HERE

PHYSICIAN OFFICE EXAMINATION NOTES:

I have reviewed this PMH; SH; FH; and ROS.	Physician's Initials	Date:
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Pertinent Medical History

ELEMENTS OF EXAM: Indicates area examined and within normal limits unless specified below.

Constitutional:

<input type="checkbox"/> Vital Signs	BP		HR		Resp Rate		Temp		Ht		Wt	
<input type="checkbox"/> General Appearance		Communication/Voice										

ENT (one required)

- EAC, TM's
- External Ears and Nose
- Nasal Mucosa, Septum, Turbinates
- Lips, Teeth, and Gums
- Oropharynx
- Pharyngeal Walls, Pyriform
- Larynx
- Nasopharynx

Lymphatic

- Cervical lymphatics

Endocrine

- Thyroid

Eyes

- Pupils

Respiratory

- Assessment of respiratory effort, stridor, symmetry, and retractions

Skin and Integument

- Rashes or Lesions on Head or Neck

Psychiatric

- Mood and Affect

Cardiovascular

- Carotid

Neurologic

- Facial Nerve Function

Focused - one system, **Expanded** - 2-7 systems, **Detailed** - 2-7 but must describe in detail, **Comprehensive** - 8 or more systems

Examination: TNE TFL TFL w/Strobe Tracheoscopy Other _____ Dictated

LPR Findings:

Pseudosulcus vocalis	2 Present			
Ventricular obliteration	2 Partial	4 Complete		
Erythema/Hyperemia	2 Arytenoids only		4 Diffuse	
Vocal fold edema	1 Mild	2 Mod.	3 Severe	4 Polypoid
Diffuse laryngeal edema	1 Mild	2 Mod.	3 Severe	4 Obstructing
Posterior commissure hypertrophy	1 Mild	2 Mod.	3 Severe	4 Obstructing
Tiger-stripe post-cricoid edema	2 Present			
Thick endolaryngeal mucus	2 Present			
Granuloma/Granulation L/R/B	2 Present			
Reflux Finding Score (RFS)				



Vocal Fold Lesions:

Ulcer/granuloma (L-R-B)	
Subglottic stenosis ()	
Leukoplakia (L-R-B)	
Carcinoma (L-R-B)	
Cyst (L-R-B)	
Web (L-R-B)	
Varix (L-R-B)	
Hemorrhage (L-R-B)	
Papilloma (L-R-B)	
Polyp (L-R-B)	
Laryngocele (L-R-B)	
Other:	

MTD Findings:

MTP I	
MTP II	
MTP III	
MTP IV	
Prenodules/Nodules	

Neuromuscular Problems:

Vocal Cord Paresis (L-R-B)	
Vocal Cord Paralysis (L-R-B)	
Spasmodic Dysphonia ()	
Dystonia Tremor	

Vocal Cord Bowing:

None	
Mild (<1mm)	
Moderate (1-2mm)	
Severe (>2mm)	

Stroboscopy:

Normal	
Suboptimal	
Abnormal	
Increased Amplitude (L-R-B)	
Decreased Amplitude (L-R-B)	
Adynamic Segment (L-R-B)	
Incomplete Glottal Closure	

<input type="checkbox"/> Radiologic studies independently reviewed	<input type="checkbox"/> Review of medical records, notes, labs, and OR reports	<input type="checkbox"/> _____ Min. spent with patient discussing:	<input type="checkbox"/> Phone call with physician
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Treatment Plan / Recommendations:

- Initial Voice Evaluation
- Barium Swallow
- LEMG
- TNE
- pH Testing On / Off
- CBC (Diff)
- CT: Neck
- Mod BASW
- MRI: Brain
- UES Manometry
- Comp. Meta. Panel
- T3,T4, TSH
- Voice Therapy
- PDL
- PFT

Physician's Signature _____ Date _____