



Baylor Scott & White

THE VOICE CENTER

A member of HealthTexas Provider Network

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Voice Center New Patient Questionnaire

Date: _____

Patient Name: _____ DOB: _____

1. What is the reason for your visit today? _____
2. When did your symptoms start? _____
3. Were there any associated illness, factors, or conditions at the time of onset?

4. How would you describe your symptoms?
 - Mild
 - Moderate
 - Severe
 - Sudden onset
 - Gradual onset
5. Do you have any of the following symptoms?
 - Hoarseness
 - Fullness in throat
 - Difficulty swallowing
 - Difficulty breathing
 - Throat pain
 - Noisy breathing
 - Burning sensation in throat
 - Excessive throat mucus
 - Feeling something stuck in throat
 - Heartburn/regurgitation
 - Chronic cough
 - Throat clearing
 - Voice Change
6. How much do you drink of the following per day?
 - Caffeine per day _____
 - Water per day _____
7. Have you had any of the following studies in the past?
 - Pulmonary function test
 - Laryngoscopy
 - Methacholine challenge test
 - Modified Barium Swallow
 - Esophagram
 - Upper GI/ Esophagoscopy
 - FEES
 - Speech Therapy
 - Chest X-ray
8. If hoarse, how does this impact your life? _____
9. If having difficulty swallowing, what foods/liquids are problematic?