Dr Peter Friedland
Adult & Paediatric Ear, Nose and Throat

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Voice Questionnaire

Name: _____ Todays Date: _____

To assist in the diagnosis and treatment of your problem, please complete the following information in as much detail as possible. This information will be treated confidentially.

Voice problem and voice use

What concerns you about your voice?

_____

_____

When did you first notice a problem with your voice? Did it start suddenly? Is it getting worse?

_____

_____

Please describe the cause of the problem, the treatment you have had, where and who treated you.

_____

_____

Please describe any feelings you have in your throat, such as a tickle, a lump, pain, dryness, difficulty swallowing, mucous, strain…

_____

_____

During the day, does your voice get:

Better? ☐ Yes ☐ No Specify: _____

Worse? ☐ Yes ☐ No Specify: _____

Stay the same? ☐ Yes ☐ No Specify: _____

Do you talk above noise? ☐ Yes ☐ No Specify: _____

Do you talk loud, yell, scream? ☐ Yes ☐ No Specify: _____

Do you sing (choir, solo, group)? ☐ Yes ☐ No Specify: _____

Are you employed? ☐ Yes ☐ No Specify: _____

If yes, what kind of work do you do? _____

Is talking required for your job? ☐ Yes ☐ No Specify: _____

If yes, how many hours per day? _____