ALLERGY ASTHMA & IMMUNOLOGY CENTER

DEMERA

Voice/LPR Medical History

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Patient Name: ____ DOB: __________________ Date: ________________

Age: _____________ Sex: _____________ Ht: _____________ Wt: _____________ BMI: ____________

Primary Physician: ___________________________________ Referring Physician: _____________________________________

Reason for Visit: ____

GENERAL VOICE/LPR QUESTIONS:

Do you have a history of GERD?.. YES / NO
If so, diagnosis made when? Tests performed? ____

Do you suffer from heart burn or acid indigestion?... YES / NO

Do you take antacids? .... YES / NO
If so, when and what dosage? ____

Do you often eat or snack before bed?... YES / NO
If so, how much time between eating and bedtime? ____

Do you often clear your throat (chronic repetitive voice clearing)? .... YES / NO
If so, what is the phlegm like? ....NONE / CLEAR / COLORED

Do you often have the feeling of fullness or even "a lump" in your throat? .... YES / NO

Have you experienced a change in voice?... YES / NO

Do you have a deeper voice? .... YES / NO

Do you have a "gravely" voice?.. YES / NO
If so, when does it occur (morning/evening/all day)? ____

Do you drink caffeinated or alcoholic beverages? .... YES / NO
If so, what and how much? ____

Do you smoke?... YES / NO
If so, what do you smoke? How often? ____

Do you use your voice a lot for work or for social activity (i.e., construction, singing, etc.)? .... YES / NO

Do you snore or have sleep apnea? .... YES / NO
If so, are you on CPAP?.. YES / NO

Do you sleep with your head flat? .... YES / NO

Do you sleep with your head elevated?.. YES / NO

What time is dinner? _______________________________ What time is bed? ___________________________________

Do you eat dessert or snack before bed?...YES / NO
How often? ____

What medications do you take for reflux? ____

Other/Explain: ____