



DEMERA

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VOICE / LPR MEDICAL HISTORY

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: _____