## Vocal Hygiene Patient Questionnaire

Name				Date
Vocal Hygiene				
Caffeine intake (glasses/cups per day	of coff	ee, soda	, tea, chocolate)	
Water intake (8-oz. glasses per day)				
Alcohol intake (drinks per week)			11 N	
Smoking history (packs per day, year	quit) _		4	
Current medications	,			W
Allergies				N a
Occupation				
Hours per day spent talking	9			
Work environment (noise level, exposure to irritants)				H
Vocal Abuse				
Do you clear your throat frequently?	Yes	No	Sometimes	Explain.
Do you cough?	Yes	No	Sometimes	Is it productive?
Do you talk excessively?	Yes	No	Sometimes	Explain.
Do you scream/yell?	Yes	No ,	Sometimes	Explain.
Do you imitate noises?	Yes	No	Sometimes	Explain.
Do you talk loudly?	Yes	No	Sometimes	Explain.
Do you grunt while exercising?	Yes	No	Sometimes	Explain.
Vocal Misuse		V.		2
Oo you talk when stressed?	Yes	No	Sometimes	Frequency?
Oo you talk when tired?	Yes	No	Sometimes	Frequency?
Oo you use a low/high pitch?	Yes	No	Sometimes	Frequency?
Oo you use character voices?	Yes	No	Sometimes	Frequency?
o you talk when you have a cold/ pper respiratory infection?	Yes	No	Sometimes	Frequency?