Vancouver Coastal Health
Promoting wellness. Ensuring care.

Vancouver General Hospital, Diamond Health Care Centre, 4th Floor 2775 Laurel Street

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PLEASE PROVIDE THE FOLLOWING INFORMATION AS ACCURATELY AND COMPLETELY AS POSSIBLE

Name		Today's Date
Date of Birth	Age	Gender ◯ M ◯ F ◯ Undeclared

	OCCUPATION(S): List all current and seasonal occupations	Number of Years	Full-Time or Part-Time	Specify %
1				
2				
3				

	REASON FOR VISIT: Describe symptoms in order of importance	How Long?
Symptom 1		
Symptom 2		
Symptom 3		

Other Concerns

Number of work days missed due to throat/voice problems

Medications and Dosage

Allergies, including Drug Allergies

Surgeries, serious illnesses, injuries and hospitalizations (descriptions and dates)

Please turn over and complete page 2

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Family History of serious illnesses, and speech and hearing problems

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Please estimate your **daily servings** of the following:

__________ Water
__________ Caffeinated Coffee
__________ Chocolate
__________ Herbal Tea, Juice (non-caffeinated/non-alcoholic beverages)
__________ Caffeinated Tea
__________ Caffeinated Soft Drinks
__________ Beer
__________ Wine
__________ Spirits

Do you smoke?	If no, are you a former smoker?	If you are a former smoker, when did you stop smoking?
◯ Yes ◯ No	◯ Yes ◯ No	

If you currently smoke, please indicate your daily consumption

________ Cigarettes ________ Cigars ________ Pipe ________ Other (medicinal or recreational)

Please check if you have ever had:

- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Arthritis
- ☐ Breathing Problem
- ☐ Chronic Fatigue
- ☐ Chronic Cough/Choking
- ☐ Depression
- ☐ Dramatic Weight Change
- ☐ Eating/Digestive Disorder
- ☐ Fibromyalgia
- ☐ Headaches (Chronic)
- ☐ Head Injury
- ☐ Hearing Problems
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ Hoarseness
- ☐ Irritable Bladder
- ☐ Irritable Bowel
- ☐ Lump in the Throat Sensation
- ☐ Multiple Chemical Sensitivity
- ☐ Nose or Sinus Problems
- ☐ Neck or Back Injury
- ☐ Neurological Disease
- ☐ Post-Nasal Drip
- ☐ Psychiatric Disorder
- ☐ Severe Snoring
- ☐ Sleep Disorder
- ☐ Swallowing Problem
- ☐ Throat Clearing
- ☐ Thyroid Problem
- ☐ TMJ Disorder
- ☐ Tremor

When was your last hearing test?	Result?

Do you use your voice in your occupation, or in performance? (If Yes, describe)

◯ Yes
◯ No

____

Do your symptoms change with the amount and type of voice use? (If yes, describe)

◯ Yes
◯ No

____

Does your voice change with your emotions? (If yes, describe)

◯ Yes
◯ No

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