Please fill out the form below before your appointment
(It will save time and make your consultation far more productive)

First/Last Name

Phone

Age

Date of Birth

Gender

Street Address

City/State

Zip/Country

Reason for consultation
(You may check more than one box)
☐ Acid Reflux (LPR and/or GERD) ☐ Chronic Cough ☐ Other

Current estimated weight
☐ Thin ☐ Normal ☐ Overweight ☐ Obese

Marital status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

If you have acid reflux, are you currently on any anti-reflux medications?
☐ Yes ☐ No

Have you had an endoscopy performed in the last two years?
☐ Yes ☐ No

If so, do you have Barrett's esophagus?
☐ Yes ☐ No

Please check any medical problems you currently experience:

☐ Allergies ☐ High Blood Pressure ☐ Heart Disease ☐ Thyroid Problems

☐ Diabetes ☐ Asthma ☐ Lung Disease ☐ Cancer ☐ Anxiety ☐ Depression

Please check any symptoms you currently experience:

Throat & Voice:

☐ None ☐ Hoarseness ☐ Voice use pain ☐ Change in voice ☐ Difficulty swallowing

☐ Sore Throat ☐ Feeling of something in your throat

Constitutional:

☐ None ☐ Fatigue ☐ Change in weight ☐ Fever ☐ Poor Appetite ☐ Headaches

Ears:

☐ None ☐ Recurrent infections ☐ Pain ☐ Hearing loss ☐ Dizziness

☐ Balance problems

Nose:

☐ None ☐ Congestion ☐ Runny nose ☐ Facial pain or pressure ☐ Loud snoring

Mouth & Neck:

☐ None ☐ Pain in neck ☐ Lumps in neck

Eyes:

☐ None ☐ Problems with vision ☐ Double vision

Skin:

☐ None ☐ Rash ☐ Change in moles

Respiratory:

☐ None ☐ Chronic cough ☐ Wheezing ☐ Shortness of breath ☐ Coughing up blood

Cardiovascular:

☐ None ☐ Chest pain ☐ Swelling in legs

Social History:

Have you ever smoked?	☐ Yes ☐ No
Do you smoke now?	☐ Yes ☐ No
Are you a former smoker?	☐ Yes ☐ No
Do you vape or use any kind of tobacco?	☐ Yes ☐ No
Do you drink alcohol?	☐ Yes ☐ No
If yes, what do you drink?	☐ Yes ☐ No
Are you currently on any medications?	☐ Yes ☐ No
Do you have any drug/medication allergies?	☐ Yes ☐ No
Are you on a salt-restricted diet?	☐ Yes ☐ No
Typically what time do you eat dinner (your evening meal)?	☐ 4pm ☐ 5pm ☐ 6pm ☐ 7pm ☐ 8pm ☐ 9pm ☐ 10pm ☐ 11pm ☐ 12am

How long have you experienced the merdical problem(s) that brought you for a consultation?

During the time that you have experienced this medical problem, how severely has it affected your quality of life?

Glottal Closure Index - Rating: 0 = No Problem / 5 = Severe

Speaking took extra effort	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Throat discomfort or pain after using your voice	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Vocal fatigue (voice weakened as you talked)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Voice cracks or sounds different	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Reflux Symptom Index (RSI) - Rating: 0 = No Problem / 5 = Severe

Hoarseness or a problem with your voice	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Clearing your throat	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Excess throat mucus or post-nasal drip	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Difficulty swallowing food, liquids, or pills	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Coughing after you ate or after lying down	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Breathing difficulties or choking episodes	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Troublesome or annoying cough	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sensartions of something sticking in your throat or a lump in your throat	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Heartburn, chest pain, indigestion, or stomach acid coming up	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

If chronic cough is your main reason for this consultation, please fill out the next section, if not leave empty:

Is chronic cough your main problem?	☐ Yes	☐ No		
For how many years have you had cough?	☐ Less than 1	☐ 2 to 3	☐ 4 to 9	☐ More than 10
Have you had a chest x-ray within the last two years?	☐ Yes	☐ No		
Have you seen a pulmonologist (lung doctor)?	☐ Yes	☐ No		

Are you on any medication for cough now?	☐ Yes	☐ No
Have you ever been on amitriptyline (Elavil), gabapentin (Neurontin), or prega balin (Lyrica)?	☐ Yes	☐ No
Do you take tramadol (Ultram), codeine, or any other narcotic analgesic for your cough?	☐ Yes	☐ No
Are you on blood pressure medication?	☐ Yes	☐ No

Koufman Cough Index™ - If you have chronic cough, please fill out this section:

Do you awaken from a sound sleep coughing violently, with or without trouble breathing?	☐ Yes	☐ No
Do you have choking episodes when you cannot get enough air, gasping for air?	☐ Yes	☐ No
Do you usually cough when you lie down onto the bed, or when you lie down to rest?	☐ Yes	☐ No
Do you usually cough after meals or eating?	☐ Yes	☐ No
Do you cough when (or after) you bend over?	☐ Yes	☐ No
Do you more-or-less cough all day long?	☐ No	☐ Yes
Does change in temperature make you cough?	☐ No	☐ Yes
Does laughing or chuckling cause you to cough?	☐ No	☐ Yes
Do fumes (perfume, automobile fumes, burned toast, etc.) cause you to cough?	☐ No	☐ Yes
Does speaking, singing, or talking on the phone cause you to cough?	☐ No	☐ Yes