



VOCAL CORD DYSFUNCTION/ BREATHING QUESTIONNAIRE

Describe the nature of your present breathing difficulty

•What does it feel like?_____

•When did it start?_____

Do you have diagnosed asthma? yes/no

If yes, how and when was it diagnosed?

If so, does your breathing problem feel the same as asthma? yes/no

If no, how is it different?_____

Do your inhalers work for your breathing problems? yes/no

If yes, how long does it take the inhaler to work?

Does your breathing problem come on slowly or suddenly?

What kinds of things trigger a breathing difficulty event?

___exercise

___sports

___nighttime (lying down)

___sitting around

___stress (work/school/family)

___coughing

___other, describe:_____

How often does an event happen? (every day, every week, every month. . .)

How long is a typical event? (number of minutes)

When was your last event?

Do you feel a tightness in your

___throat

___chest

___both

___other, describe:_____

I have the most trouble with

___inhaling

___exhaling

___both

Does your throat make a noise when you have trouble breathing? yes/no

What does it sound like?_____

Have you ever passed out?

Do you have numbness or tingling around your lips/fingertips when you have trouble Breathing?

Have you ever been treated in the ER for this breathing difficulty? yes/no
If so, how many times?

Does anything help you when you have trouble breathing? yes/no

What helps?_____

How quickly can you resume your activity after a breathing difficulty episode?

When you resume your activity, does the breathing problem come back? yes/no

Does this condition limit your activities or lifestyle? yes/no

Do you have allergies? If so, please list your allergies:_____

Were your allergies diagnosed by an allergist? yes/no

Does the quality of your voice change when you have a breathing event? yes/no

Describe the change:_____

Have you ever experienced voice hoarseness? yes/no How often? _____

Did your voice change begin with the onset this breathing difficulty? yes/no

Have you had any voice changes with the use of inhalers? yes/no

Do you have any of the following symptoms/behaviors? Check any that apply:

- Tickle in the throat
- Burning/acid sensation
- Globus/lump in the throat
- Trouble swallowing
- Chronic cough/throat clearing
- Regurgitation
- Pain with swallowing
- Sensation of mucous or phlegm in the throat
- Dry mouth or throat
- Heartburn
- Frequently eating late at night
- Recurring sore throat
- Frequent burping/smelly burps
- "morning" voice (worse in the morning)
- Choking sensation
- Bitter taste in mouth

Please list any surgeries with the dates (approximate, if difficult to recall):

Please list other medical conditions for which you have been or are currently being treated:

Please list all prescription and over the counter medications that you take:

Lifestyle

Smoking history (or exposure to smoking):

Alcohol usage per day or week:

Caffeine consumption per day:

Eating schedule/habits:

What do you do at work or home on a regular basis?

Do you consider your work away or at home stressful? yes/no

Describe:

Do you play any sports? If so, which ones?

Do you think you get enough exercise? yes/no

How would you describe your physical fitness?

Are you being seen by a medical specialist other than your primary physician? yes/no

If so, whom: