TexasVoiceCenter
Voice, Swallowing, and General ENT

HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

Dear Patient:

Thank you for choosing the Texas Voice Center at Houston Methodist for your otolaryngology specialty care. Dr. Thekdi and the Texas Voice Center provide state-of-the-art care for all voice-related disorders, as well as swallowing and general ENT disorders.

To enable our office to provide more timely service, please complete these forms prior to your visit and present them to our front desk receptionist upon your arrival. Insurance company policies require proof of identity- ***patients/guardians or your representative must present a photo ID and your insurance card/documentation at the time of your clinic visit.***

If a referral is required by your managed care plan, it MUST be received in our office by your appointment time. If we have not received the referral by the time of your arrival, your appointment will be rescheduled.

As we are subspecialists and often use special equipment for diagnostic and treatment purposes during office visits, certain procedures performed during typical office visits are usually not covered under insurance copay policies but fall under a procedure category that may apply toward your coinsurance or deductible. When this is the case, you will be responsible for the copay plus the coinsurance/deductible amount. You can call the office the day prior to your appointment for an estimate of the amount for which you will be responsible.

All patients are seen in the order of scheduled appointments only. Traffic and parking can sometimes cause delays, so please allow enough travel time to assure your prompt arrival. As parking is sometimes difficult to find, using the Valet parking service can be very convenient. Valet parking rates range from $10.00 (up to 2 hours) to $13.00 for up to 24-hours.

In consideration of other patients, please call (713) 796- 2181 at least twenty-four hours prior to your scheduled appointment if you are unable to keep your appointment so that we can help you reschedule.

If you are scheduled for an evaluation of a chronic problem (lasting more than 3-4 weeks) and you develop an acute illness, please call us to reschedule your appointment, as the acute illness may interfere with the proper diagnosis of the underlying chronic condition.

Patients coming for evaluation of throat or voice problems: If you are not diabetic, please do not eat 3 hours before your appointment; if you are diabetic, please eat enough prior to the appointment to keep your sugar from dropping. Drinking water before the appointment is okay for all patients.

We look forward to seeing you and assisting in your care.

Sincerely yours,

Dr. Apurva Thekdi, and Staff

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WE TRY TO EXCEED YOUR EXPECTATIONS!

Welcome to the Texas Voice Center! Our medical and support staff are here to serve you, and want you to know what to expect when you come to our office. We offer this information in an effort to guide you through the Texas Voice Center experience, from your first appointment through your follow-up visits.

TO OUR VOICE PATIENTS:

When someone develops a voice disorder, there can be physical, emotional, professional, social and financial consequences. Because your vocal demands are unique, we provide personalized care, state-of-the-art technology and procedures, and a concerned support staff to help you recover your best voice.

MAKING AN APPOINTMENT

When you become aware of any negative change in your voice (pitch, quality, endurance, etc.), call the Texas Voice Center at (713) 796-2181. The Texas Voice Center secretary will talk with you about your voice symptoms, schedule an appointment, and remind you to fast three hours prior to your appointment. The receptionist can also discuss the fee schedule and your insurance information to verify coverage before you come in. Please complete the following forms prior to your scheduled appointment time.

YOUR FIRST VISIT

To better understand your needs, we will ask you to complete a special form for singers and actors. If you are experiencing an "acute" problem, one that has persisted for 2-5 days, we will try to schedule your visit immediately. **If you are scheduled for an evaluation of a chronic problem (lasting more than 3-4 weeks) and you develop an acute illness, please call us to reschedule your appointment, as the acute illness may interfere with the proper diagnosis of the underlying chronic condition.** A comprehensive evaluation of chronic problems will include:

OBJECTIVE VOICE ANALYSIS: We will use a computer program to analyze samples of your speaking and singing voice to obtain an accurate "picture" of your current voice. This visual profile reveals your spoken pitch range, and the status of eighteen different parameters of your voice when speaking and singing. These parameters include the status of your vocal strength, symmetry of vocal fold movements, variations in pitch and breath control, tremor, air leakage, and voice breaks.

PULMONARY FUNCTION STUDY: As breath support is the foundation for your voice, it is imperative to determine the status of your lung capacity that undergirds the voice.

MEDICAL HISTORY: A complete medical history will be taken. Please bring a ***list of all*** herbs, prescriptions, over-the-counter medications and other drugs you are currently taking.

VIDEOSTROBOSCOPY: Our state-of-the-art videostroboscopy equipment greatly enhances our ability to accurately assess how a particular pathology affects the ability of the vocal folds to vibrate in a normal way. The doctor uses a rigid scope to examine laryngeal anatomy and vocal fold movement, and a flexible scope for a similar examination during speaking and singing. For the examination, we ask that you not eat three (3) hours prior to your appointment, but you may drink water. Please take all medications as you usually do with a little food, if needed. If you are diabetic, please follow your normal eating routine.

DIAGNOSIS AND RECOMMENDED TREATMENT: After reviewing all the information listed above, the doctor will make a diagnosis, and recommend appropriate treatment and a follow-up visit.

SPEECH THERAPY: Our ASHA Certified Speech-Language Pathologist, who has expertise in treating voice disorders, will evaluate your voice during your first visit. If the doctor determines your treatment also requires voice intervention, you may be referred to our Speech-Language Pathologist for that intervention. Competent voice intervention by a qualified Speech Pathologist is often a medical necessity, and a mandatory part of voice management.

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6550 Fannin, Suite 1723
Houston, TX 77030
(713) 796-2181

PATIENT INFORMATION—PLEASE PRINT

Last Name:	**First Name:**	**Middle Initial:**	
Circle: Mr Mrs Miss MD PhD DDS	**Marital Status:**	**Spouse's Name:**	
☐ **Male** ☐ **Female** **Race:**	**Birth Date:**	**Age:**	**Hispanic/Latino:** ☐ **Yes** ☐ **No**
Home Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone:**	
Email Address:			
Social Security #:	**Driver License #:**	**State:**	
Occupation:	**Other Family Members Seen by TVC:**		
Pharmacy Name & Address	**Pharmacy Phone:**		**Pharmacy Fax:**
Employer & Address:	**City:**	**State:**	**Zip:**
If Student, School Attending:	☐ **Full Time** ☐ **Part Time:**		
Full Name of Referring Physician:	**Address:** **City:**	**State:**	**Zip:**
Other Physicians Caring for You:	**Specialty:**	**Phone:**	
In Case of Emergency, Notify:	**Relationship to you:**	**Home #:**	**Other #:**
Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:			

FINANCIALLY RESPONSIBLE PARTY (if other than patient)

Last Name:	**First Name:**	**Middle Initial:**	
Home Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Relationship to patient:**	
Social Security #:	**Driver License #:**	**Birth Date:**	**Age:**
Employer & Address:	**City:**	**State:**	**Zip:**

AUTHORIZATION

I hereby authorize the Texas Voice Center to furnish information associated with this illness/accident to my referring physician, other allied health professionals, or my insurance carrier.

Patient/Guarantor Signature: _____ **Date:** _____

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Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Weight:** _____ **Height:** ____'____"

What is your reason for visit? _____

Date symptoms began? _____

Severity of symptoms: ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Incapacitating**

Aggravated by: _____

Relieved By: _____

How many times have you been treated for the problem? _____

List full names & locations of physicians who have treated you for this condition: _____

Have you taken any aspirin or ibuprofen products (Advil, Aleve, etc.) during the past month? Y / N

If yes, what did you take? _____ **When?** _____ **For how long?** _____

Are you taking it now? Y / N

Symptoms Check (✓) symptoms you currently have or have had recently.

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Weakness

Respiratory
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing
- ☐ Cough

Cardiovascular
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Heart problems

Metabolic/Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn or acid reflux
- ☐ Vomiting
- ☐ Nausea

Genitourinary
- ☐ Change in urine color
- ☐ Kidney problems
- ☐ Painful urination
- ☐ Frequent urination

Neurological
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Excessive daytime sleepiness
- ☐ Non-restorative sleep
- ☐ Numbness in legs or arms
- ☐ Blackouts or fainting
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness
- ☐ Headaches
- ☐ Seizures
- ☐ Confusion or memory loss

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Nervousness or increased stress

Dermatologic
- ☐ Skin rash

Musculoskeletal
- ☐ Back pain
- ☐ Bone/joint symptoms
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Rheumatologic symptoms

Immunological
- ☐ Hay fever
- ☐ Hives
- ☐ Chemical sensitivity
- ☐ Environmental allergies
- ☐ Food allergies/sensitivity

Patient Name:_____ DOB: _____

HEENT

Head/Eyes

- ☐ Headache
- ☐ Burning eyes
- ☐ Double vision
- ☐ Discharge from eyes
- ☐ Dry eyes
- ☐ Feeling of something in the eye(s)
- ☐ Sensitivity/pain of eyes to light
- ☐ Redness of the eye(s)
- ☐ Itchy eye(s)
- ☐ Nystagmus
- ☐ Eye pain
- ☐ Scotoma
- ☐ Eye Floaters
- ☐ Tearing
- ☐ Loss of vision

Ears

- ☐ Ear discharge
- ☐ Excessive ear wax
- ☐ Fullness in ears
- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Ear pain
- ☐ Tinnitus or ringing in the ears
- ☐ Vertigo
- ☐ Excessive noise exposure

Nose/Sinus

- ☐ Reduced sensation of smell
- ☐ Nasal drainage
- ☐ Nose bleed
- ☐ Facial pain
- ☐ Nasal congestion
- ☐ Nasal obstruction
- ☐ Runny nose
- ☐ Sinusitis
- ☐ Sneezing

Mouth/Throat

- ☐ Change in taste
- ☐ Voice change
- ☐ Cold sores
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Lump in throat
- ☐ Mouth sores
- ☐ Pain when swallowing
- ☐ Post nasal drip
- ☐ Tongue soreness
- ☐ Sore throat/pharyngitis
- ☐ Snoring
- ☐ Tooth pain

Neck

- ☐ Lumps in neck
- ☐ Swollen glands in neck
- ☐ Pain in neck

Other:

_____
_____
_____
_____
_____

Conditions

Check (✓) conditions you currently have or have had in the past year.

Past medical History

- ☐ Environmental Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostaic Hypertrophy
- ☐ Blood Clots
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertensions
- ☐ Irritable Bowel Diseases
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure
- ☐ Thyroid Disease

Other: _____
_____
_____

Past Surgical Histories *(with approximate dates)*

Other: _____
_____
_____

Family History

Who:	What Condition:	Age of Onset:	Cause of death?

Patient Name:_____ DOB: _____

Social History

Tobacco Use: ☐Yes ☐No ☐Former
Type: _____
Packs/amount per day: _____
Years Smoked: _____
Year Quit: _____

Drinks Alcohol: ☐Yes ☐No ☐Formerly Year Quit: _____
Type: _____ Frequency: _____
Amount: _____ Last Drink:_____

Caffeine Use:
Type: _____
Amount daily: _____

How much water do you drink in a day?

_____

Do you consider yourself a Performing or Visual Artist? ☐Yes ☐No

Occupation:
Employer: _____ Occupation: _____
Employment status: _____ Restrictions: _____

Medications

List all prescription and over-the-counter medications and their dosages you are currently taking- **please ensure that spelling is correct**

_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies, Severity & Reaction

_____ _____
_____ _____
_____ _____

Preferred Pharmacy: _____ Phone: _____

To the best of my knowledge the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____ _____
Please print name of patient, parent, guardian, or personal representative Date

_____ _____
Reviewed by Date

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Apurva A. Thekdi, MD
6550 Fannin Street, Suite 2025
Houston, Texas 77030-2717

713-796-2181 713-796-2349 fax

RELEASE OF MEDICAL RECORDS

Date: _____

To: _____
Name

_____
Street

_____
City State ZIP

Re: Patient Name: _____ Birthdate:_____

Gender: _____ Social Security Number_____

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information:

_____Complete record
_____Record of care from _____to_____, only
_____Record of care concerning the following condition(s)_____
_____
_____Other, Specify:_____
_____Confer with another person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

Initial:_____ Date:_____

The reason or purpose for this release of information is as follows:_____
_____

I understand that you will provide this information within 15 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners) and that a fee for preparing and furnishing this information may be charged. (The fee will be waived if the records are to be used for supporting an application for disability or other benefits or assistance under a) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old-Age and Survivors Insurance. I have attached a statement that confirms that such an application or appeal has been filed or is pending.

Signed:_____ Date_____
(Patient or person legally authorized to consent on patient's behalf)