Patient questionnaire: Inability to belch

The aim of this questionnaire is to find out whether you correspond to the entity of RCPD (retrograde cricopharyngeal muscle dysfunction) and therefore if you would be a candidate for the Botox procedure. Filling out carefully can save you a lot of time and avoid a unnecessary visit or even a procedure. In addition this questionnaire will help us to describe your condition better and may therefore be used for scientific studies evidently without disclosing your identity in any way.

Name:

Date:

Date of birth:

Primary care physician (name, address):

Who referred you to this office? *(Please circle the correct answer)*

Friend/Internet/Hospital/voice teacher/television/insurance company/speech pathologist/newspaper/professional organization/other: ______________________________

Problem overview

1. When and how did you become aware of your inability to belch?

2. Do you experience abdominal bloating? Explain:

3. What about gurgling noises? Describe:

4. Does it cause pain? If so, describe the nature, severity, location:

5. What is the main problem it causes you?

6. Do you experience excessive flatulence?

7. Do you think your ability to vomit is different from other people? If so, describe

8. To your knowledge, was it already hard to burp for you as an infant? Were you gassy or colicky?

9. Do you experience heartburn or acid belching?

10. How does this problem affect your lifestyle? What adjustments have you made to your social life?

11. Previous diagnosis and treatment elsewhere:

12. Circle the number on the scale below which indicates how severe your problem seems to you:

1 2 3 4 5 6 7

13. How motivated would you say you are to solve this problem?

1 2 3 4 5 6 7

14. Is there anything else you would like to share about your problem? (Please describe)

Additional history

15. Please circle the number below which corresponds to how talkative you believe you are, by nature *(not by occupation or other circumstance)*

    1 2 3 4 5 6 7

16. How would you describe the loudness of your conversational voice?

    1 2 3 4 5 6 7

17. Vocal commitments *(please describe)*:

18. Any voice training? If so, number of years: ________; Teacher(s): ____

Medical History

19. Check all that apply *(please circle all that apply)*

    Heart attack/Heart failure/high blood pressure/osteoarthritis/rheumatoid arthritis/ Kidney failure/gout/GERD or Acid Reflux/diabetes/stroke/seizures/mental illness/kidney stones/blood clot in leg/osteoporosis/allergies/lung disease/HIV/AIDS/tuberculosis/asthma/blood clot in lung/alcoholism/liver trouble/hepatitis/thyroid/bleeding/anemia/cancer/stomach ulcers/serious injury (*please explain*:)____
    ____
    Other:____
    ____
    ____

Surgical history

20. List previous procedures you have had, if any:

Operation	Surgeon	Date

☐ None

Family history

21. Check all that apply *(please circle all that apply)*
Stroke/heart trouble/high blood pressure/chronic cough/arthritis/gout/bleeding disorders/asthma/mental illness/kidney trouble or stones/spine problems/GERD or Acid reflux/alcoholism/seizures/diabetes
Neurological disorder:____
Psychiatric disorder:____
Cancer:____
Other:____

☐ None apply

22. List medications you take, if any:

23. Do you have any allergies or adverse reactions to medications?
☐ No, none
☐ Yes *(please list)*:
____
____
____

24. Do you have a living will?
☐ No
☐ Yes

Social history

25. Tobacco use (please circle the correct answer):

☐ Never

☐ If current: ______/packs/day for _____years

☐ cigar ☐ chew ☐ pipe

☐ If former: ______/packs/day for _____years

☐ cigar ☐ chew ☐ pipe

26. Alcohol use:

☐ None at all

☐ 1-3 beverages per week

☐ 4-8 beverages per week

☐ 8+ beverages per week

27. Other

☐ Caffeinated beverages per day:____

☐ Total fluids (in cups) per day:____

Review of systems

28. Check all that apply *(please circle all that apply):*
Reading glasses/change of vision/loss of hearing/ear pain/toothache/gum trouble/nosebleeds/frequent headaches/dizziness/blackouts/seizures/numbness or tingling/abnormal heartbeat/heart or chest pain/chronic pain/arthritis/calf cramps with walking/swollen ankles/cold intolerance/recent weight change/poor appetite/difficulty swallowing/stomach pain/nausea or vomiting/fever or chills/frequent urination/burning on urination/difficulty urinating/frequent constipation/hemorrhoids/skin rash/hot or cold/irregular periods/frequent spotting/nervous/ulcers/heartburn/acid belching/morning sore throat/morning cough/morning mucus/hoarseness/breathing problem/snoring/breath-holding at night/Other:____

Other diseases *(please specify: who, what kind of disease)*:

____

____

____

Thank you for filling out this questionnaire!