Q - Generic - Confounders

Record ID

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Questionnaire - Metadata

Session ID

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Questionnaire Started At

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Questionnaire Completed At

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Questionnaire Duration (seconds)

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TELL US ABOUT YOUR HEALTH

MEDICAL HISTORY
There are some medical conditions that could have long term effects on your voice. In the following questions you will be asked about your CURRENT conditions as well as those you may have had in the PAST. Please read each set of questions carefully.

NOTE: [All fields will be pre-populated to NO/NEVER unless the person noted the condition at enrollment. E.g. if the person enrolled with chronic cough, then "Chronic cough" will be pre-populated to YES/CURRENT.]

Have you ever been diagnosed by a doctor with any of the following conditions that affect your EARS, NOSE, or MOUTH?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition	Yes	No	Prefer Not to Answer
Chronic ear infections	◯	◯	◯
Cleft lip	◯	◯	◯
Cleft palate	◯	◯	◯
Craniofacial trauma	◯	◯	◯
Hearing loss	◯	◯	◯
Seasonal allergies	◯	◯	◯
Sinusitis (rhinitis)	◯	◯	◯

Sjögren's syndrome	◯	◯	◯
Velopharyngeal insufficiency (e.g. hyponasality, nasal emission, etc.)	◯	◯	◯

Do you currently have any dental condition(s) (e.g. tooth loss, dentures, retainer, braces, etc.)?

◯ Yes
◯ No
◯ Prefer Not to Answer

Please specify what dental condition(s) you have.

_____

Do you currently have any other condition(s) of your ear, nose, or mouth?

◯ Yes
◯ No
◯ Prefer Not to Answer

Please specify what other condition(s) of your ear, nose, or mouth you have.

_____

Have you ever been diagnosed by a doctor with any of the following conditions that affect your THROAT? Please check all that apply.

To save you time, the responses are pre-set to "NEVER". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition	Past	Current	Never	Prefer Not To Answer
Acid reflux (e.g. heart burn, GERD, etc.)	☐	☐	☐	☐
Airway stenosis (e.g. glottal, subglottal, tracheal, etc.)	☐	☐	☐	☐
Chronic cough	☐	☐	☐	☐
Glottic insufficiency, presbyphonia	☐	☐	☐	☐
Laryngitis	☐	☐	☐	☐
Laryngospasm, irritable larynx	☐	☐	☐	☐
Muscle tension dysphonia	☐	☐	☐	☐
Swallowing disorder/dysphagia	☐	☐	☐	☐
Thyroid disease (e.g. thyroid polyp, Hashimoto's Grave's disease, hypo/hyperthyroidism, etc.)	☐	☐	☐	☐
Vocal cord dysfunction/paradoxical vocal fold motion	☐	☐	☐	☐
Vocal fold hemorrhage or bleed	☐	☐	☐	☐

Lesions of the vocal cord	☐	☐	☐	☐
Vocal fold paralysis (bilateral)	☐	☐	☐	☐
Vocal fold paralysis (unilateral)	☐	☐	☐	☐
Other throat condition	☐	☐	☐	☐

Please specify what other throat condition(s) you currently have. _____

Do you feel as though everyday environmental pollution (e.g. smog, smoke, dust, etc) significantly affects your breathing or voice?

- ◯ Yes
- ◯ No
- ◯ Not certain
- ◯ Prefer Not to Answer

Have you ever been diagnosed by a doctor with any of these other SPEECH conditions?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

	Yes	No	Prefer Not To Answer
Apraxia of speech	◯	◯	◯
Ataxia	◯	◯	◯
Dysarthria	◯	◯	◯
Stutter/dysfluency	◯	◯	◯
Other speech condition	◯	◯	◯

Please specify what other speech condition(s) you have. _____

Have you ever had any of the following surgical interventions for your EAR, NOSE, MOUTH, THROAT, or SPEECH condition(s)?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you have never had the surgical intervention, you can leave the response as it is.

Surgical Intervention

	Yes	No	Prefer Not To Answer
Airway surgery/reconstruction BELOW the vocal folds (e.g. tracheal reconstruction, balloon dilation, etc.)	◯	◯	◯
Chronic ear surgery (e.g. mastoid surgery, etc.)	◯	◯	◯
Cochlear implant	◯	◯	◯

Cordotomy, arytenoidectomy, arytenoid tie back, etc.	○	○	○
Ear tubes	○	○	○
Esophageal dilation	○	○	○
Nose surgery (e.g. septoplasty, rhinoplasty, etc.)	○	○	○
Sinus surgery	○	○	○
Sleep surgery (e.g. implantable device for sleep apnea, etc.)	○	○	○
Tonsillectomy (with or without adenoidectomy)	○	○	○
Tracheostomy	○	○	○
Other surgical treatment for an ear, nose, mouth, throat, or speech condition	○	○	○

Please specify what other surgical treatment(s) you have received for your ear, nose, mouth, throat, or speech condition(s). _____

Have you ever had any of the following non-surgical interventions for your EAR, NOSE, MOUTH, THROAT, or SPEECH condition(s)? Please check all that apply.

To save you time, the responses are pre-set to "NEVER". Please only change the responses that apply to you. If you have never had the intervention, you can leave the response as it is.

Non-surgical Intervention

	Past	Current	Never	Prefer Not To Answer
Botox injections for laryngeal dystonia	☐	☐	☐	☐
C-Pap	☐	☐	☐	☐
Injection/implant to the vocal folds	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Radiation to the head or neck	☐	☐	☐	☐
Speech, voice, or swallowing therapy	☐	☐	☐	☐
Other non-surgical treatment for an ear, nose, mouth, throat, or speech condition	☐	☐	☐	☐

Please specify what other non-surgical treatment(s) you are currently receiving for your ear, nose, mouth, throat, or speech condition(s). _____

Have you ever been diagnosed by a doctor with any of the following LUNG conditions?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition	Yes	No	Prefer Not To Answer
Asthma	◯	◯	◯
Bronchiectasis	◯	◯	◯
Chest wall trauma	◯	◯	◯
Chronic obstructive pulmonary disease (COPD)	◯	◯	◯
COVID	◯	◯	◯
Emphysema	◯	◯	◯
Interstitial lung disease (e.g. sarcoidosis, pulmonary fibrosis)	◯	◯	◯
Obstructive sleep apnea (OSA)	◯	◯	◯
Pneumothorax or atelectasis (e.g. collapsed lung)	◯	◯	◯
Pulmonary hypertension	◯	◯	◯
Recurrent bronchitis	◯	◯	◯
Tuberculosis	◯	◯	◯

Have you tested positive for COVID in the last 10 days?

◯ Yes
◯ No
◯ Prefer Not To Answer

Do you currently have any other lung condition?

◯ Yes
◯ No
◯ Prefer Not To Answer

Please specify what other lung condition(s) you currently have.

_____

Have you ever had any of the following interventions for your LUNG condition(s)?

To save you time, the responses are pre-set to "No". Please only change the responses that apply to you. If you have never had the intervention, you can leave the response as it is.

Treatment	Yes	No	Prefer Not To Answer
Chest surgery (e.g. bronchoscopy, thoracic surgery, etc.)	◯	◯	◯

Lobectomy	◯	◯	◯
Medication	◯	◯	◯
Prolonged intubation (more than 7 days)	◯	◯	◯
Radiation to the chest	◯	◯	◯
Supplemental oxygen	◯	◯	◯

Are you currently receiving any other treatment(s) for your lung condition(s)?

◯ Yes
◯ No
◯ Prefer Not To Answer

Please specify what other treatment(s) you are receiving for your lung condition(s). _____

Have you ever been diagnosed by a doctor with any of the following NEUROLOGICAL conditions?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition

	Yes	No	Prefer Not To Answer
Brain tumor	◯	◯	◯
Epilepsy	◯	◯	◯
Multiple sclerosis	◯	◯	◯
Parkinson's Disease	◯	◯	◯
Stroke/aphasia	◯	◯	◯
Traumatic brain injury	◯	◯	◯

Do you currently have any other neurological condition(s)?

◯ Yes
◯ No
◯ Prefer Not To Answer

Please specify what other neurological condition(s) you currently have. _____

Have you ever had any of the following interventions for your NEUROLOGICAL condition(s)? Please check all that apply.

To save you time, the responses are pre-set to "NEVER". Please only change the responses that apply to you. If you have never had the intervention, you can leave the response as it is.

Treatment

	Past	Current	Never	Prefer Not To Answer

Deep brain stimulator	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Vagal nerve stimulator	☐	☐	☐	☐
Other treatment for a neurological condition	☐	☐	☐	☐

Please specify what other treatment(s) you are currently receiving for your neurological condition(s). _____

Have you ever been diagnosed by a doctor with any of the following PSYCHOLOGICAL conditions? Please check all that apply.

To save you time, the responses are pre-set to "NEVER". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition	Past	Current	Never	Prefer Not To Answer
Alcohol or substance use disorder	☐	☐	☐	☐
Anxiety disorder (e.g. generalized or social anxiety disorder)	☐	☐	☐	☐
Attention deficit/hyperactivity disorder (ADHD)	☐	☐	☐	☐
Autism spectrum disorder (ASD)	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐
Borderline personality disorder (BPD)	☐	☐	☐	☐
Depression or major depressive disorder	☐	☐	☐	☐
Eating disorder (ED)	☐	☐	☐	☐
Obsessive compulsive disorder (OCD)	☐	☐	☐	☐
Panic disorder	☐	☐	☐	☐
Post-traumatic stress disorder (PTSD)	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐
Other psychological condition	☐	☐	☐	☐

Please specify what other psychological condition(s) you have. _____

Have you ever had any of the following interventions for your PSYCHOLOGICAL condition(s)? Please check all that apply.

To save you time, the responses are pre-set to "NEVER". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Treatment

	Past	Current	Never	Prefer Not To Answer
Talk therapy with a mental health professional (e.g. social worker, psychiatrist, etc.)	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Mindfulness, meditation	☐	☐	☐	☐
Other treatment for a psychological condition	☐	☐	☐	☐

Please specify what other treatment(s) you are currently receiving for your psychological condition(s). _____

Have you ever been diagnosed by a doctor with any of the following CANCERS? Please check all that apply.

To save you time, the responses are pre-set to "Never". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition

	Past	Current	Never	Prefer Not To Answer
Brain cancer	☐	☐	☐	☐
Ear cancer	☐	☐	☐	☐
Laryngeal cancer (e.g. vocal folds, epiglottis, etc.)	☐	☐	☐	☐
Lung cancer	☐	☐	☐	☐
Oral cancer (e.g. tongue, mouth, gum, tonsil, etc.)	☐	☐	☐	☐
Sinus cancer	☐	☐	☐	☐
Esophageal cancer	☐	☐	☐	☐
Thyroid cancer	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐

Please specify what other cancer(s) you have had in the past. _____

Please specify what other cancer(s) you have currently. _____

Have you ever had any of the following interventions for your CANCER(S)? Please check all that apply.

To save you time, the responses are pre-set to "NEVER". Please only change the responses that apply to you. If you have never had the intervention, you can leave the response as it is.

Treatment

	Past	Current	Never	Prefer Not To Answer
Chemotherapy	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Immunotherapy	☐	☐	☐	☐
Radiation	☐	☐	☐	☐
Radioactive Iodine	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Experimental treatment / clinical trial	☐	☐	☐	☐
Other cancer treatment	☐	☐	☐	☐

Please specify what experimental treatment (e.g. clinical trial) you received in the past. _____

Please specify what experimental treatment (e.g. clinical trial) you are currently receiving. _____

Please specify what other cancer treatment(s) you have received in the past. _____

Please specify what other cancer treatment(s) you are currently receiving. _____

Have you ever been diagnosed by a doctor with any of these OTHER health conditions?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you have never had the condition, you can leave the response as it is.

Condition

	Yes	No	Prefer Not To Answer
Atrial fibrillation	◯	◯	◯
Chronic pericarditis	◯	◯	◯
Congestive heart failure	◯	◯	◯
Coronary heart disease	◯	◯	◯
Chronic kidney disease	◯	◯	◯
Obesity	◯	◯	◯

Scoliosis	◯	◯	◯

Are you currently considered obese?
◯ Yes
◯ No
◯ Prefer Not To Answer

Do you currently have diabetes?
◯ Yes
◯ No
◯ Prefer Not To Answer

Which type of diabetes do you have?
◯ Type 1
◯ Type 2
◯ Gestational diabetes
◯ LADA/Type 3a
◯ Not certain

Do you currently have any other heart disease(s)?
◯ Yes
◯ No
◯ Prefer Not To Answer

Please specify what other heart condition(s) you have.
_____

Do you currently have any infectious disease?
◯ Yes
◯ No
◯ Prefer Not To Answer

Please specify what other infectious disease(s) you have.
_____

Do you currently take or use any of these medications or substances to treat ANY condition (e.g. using antidepressant to treat ADHD)?

To save you time, the responses are pre-set to "No". Please only change the responses that apply to you. If you are not currently taking the medication, you can leave the response as it is.

Medication

	Yes	No
Anti-anxiety medication	◯	◯
Antibiotics	◯	◯
Anticholergenics	◯	◯
Antidepressants	◯	◯
Antiepileptics	◯	◯
Allergy medications (antihistamines)	◯	◯
Blood pressure medications (anti-hypertensive)	◯	◯

Pain medications	◯	◯
Decongestants	◯	◯
Diuretics	◯	◯
Hormones	◯	◯
Immune suppressors	◯	◯
Inhaled corticosteroids	◯	◯
Muscle relaxants	◯	◯
Oral steroids	◯	◯
Psychotropic/antipsychotic medications	◯	◯
Reflux medications	◯	◯
Stimulants	◯	◯

Which Pain Medication(s) do you currently take?

To save you time, the responses are pre-set to "No". Please only change the responses that apply to you. If you are not currently taking the medication, you can leave the response as it is.

Medication	Yes	No
Analgesics	◯	◯
NSAIDs	◯	◯
Opiates	◯	◯
Neuro-modulators	◯	◯

Which Hormone(s) do you currently take?

To save you time, the responses are pre-set to "No". Please only change the responses that apply to you. If you are not currently taking the medication, you can leave the response as it is.

Medication	Yes	No
Androgenic steroids	◯	◯
Hormonal replacement therapy (HRT)	◯	◯
Insulin	◯	◯
Contraceptive, birth control	◯	◯
Thyroid replacement	◯	◯
Other hormone replacement	◯	◯

What other hormone replacement(s) do you currently take? _____

Are you experiencing any of the following symptoms today?

To save you time, the responses are pre-set to "NO". Please only change the responses that apply to you. If you are not experiencing the symptom, you can leave the response as it is.

Symptom	Yes	No
Anxiety or nervousness	◯	◯
Confusion	◯	◯
Coughing or clearing your throat	◯	◯
Dizziness	◯	◯
Headache or migraine	◯	◯
Nasal congestion or obstruction	◯	◯
Scratchy or sore throat	◯	◯
Shortness of breath	◯	◯
Sleep disturbance	◯	◯
Speech difficulty	◯	◯

Gynecological

Do you currently have periods (with regular or irregular cycles)?

◯ Does not apply (i.e. I am a male who has never had a period)
◯ Yes
◯ No, but I used to
◯ Prefer not to answer

Where in your cycle are you? We ask because this may affect your voice.

◯ Menstruating
◯ Premenstrual
◯ Postmenstrual
◯ Not certain
◯ Prefer not to answer

Please explain

◯ I am currently pregnant
◯ I'm using birth control
◯ I have an IUD [DEPRECATED]
◯ I have gone through menopause or have had a hysterectomy
◯ I no longer have my period due to hormone therapy
◯ Prefer not to answer
◯ Other

If you selected "other" please specify:

_____

Which trimester of pregnancy are you in?

◯ First trimester (less than 14 weeks)
◯ Second trimester (14-28 weeks)
◯ Third trimester (more than 28 weeks)
◯ Not certain
◯ Prefer not to answer

PHYSICAL HEALTH

Some aspects of your physical health can affect the sound of your voice. This section asks questions about some of these factors.

Height and Weight

Unit	◯ Metric ◯ US customary units
Height	_____ (inches)
Weight	_____ (lbs)

Overall Health

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please choose only one response.

In the past 30 days, how much difficulty did you have in:

	None	Mild	Moderate	Severe	Extreme or cannot do
Standing for long periods such as 30 minutes?	◯	◯	◯	◯	◯
Taking care of your household responsibilities?	◯	◯	◯	◯	◯
Learning a new task, for example, learning how to get to a new place?	◯	◯	◯	◯	◯
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	◯	◯	◯	◯	◯

How much have you been emotionally affected by your health problems?	○	○	○	○	○
Concentrating on doing something for ten minutes?	○	○	○	○	○
Walking a long distance such as a kilometre [or equivalent]?	○	○	○	○	○
Washing your whole body?	○	○	○	○	○
Getting dressed?	○	○	○	○	○
Dealing with people you do not know?	○	○	○	○	○
Maintaining a friendship?	○	○	○	○	○
Your day-to-day work?	○	○	○	○	○

Overall, in the past 30 days, how many days were these difficulties present?

_____
(days)

In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?

_____
(days)

In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?

_____
(days)

DAY TO DAY ACTIVITIES

Things you do on a daily basis (including your job, work environment, hydration, etc.) can affect the sound of your voice OR affect the way you complete the tasks in this study. This section asks questions about some of these factors.

Voice Use

Do you do one of these jobs or hobbies that requires using your voice for many hours a day? Check all that apply

- ☐ Administrative assistant
- ☐ Attorney
- ☐ Bartender
- ☐ Barista
- ☐ Call center worker
- ☐ Cheerleader
- ☐ Child-care provider
- ☐ Exercise instructor
- ☐ Minister/Preacher
- ☐ Parent, guardian, or caregiver
- ☐ Public Speaker
- ☐ Receptionist
- ☐ Salesperson
- ☐ Singer
- ☐ Teacher
- ☐ Waiter
- ☐ Other
- ☐ NONE OF THE ABOVE

Please specify what other job or hobby you have that requires you to use your voice loudly for many hours a day.

_____

How many hours per day do you do this activity with a loud voice or in a loud environment that requires elevating your voice (for instance, a noisy bar or a noisy classroom)?

_____
(hours)

Reading Ability

How good do you think you are at reading out loud in [English/Spanish], - that is, reading out loud at a normal rate without making mistakes and understanding what you read?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

Tiredness

How tired are you?
0=not tired at all, 10=extremely tired

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Hydration

On a typical day, how many small (8oz or 230mL) cups of water do you drink?

_____
(Number)

Today, how many small (8oz or 230mL) cups of water have you had?

_____
(Number)

Caffeine intake

On a typical day, do you drink coffee or use other caffeinated products?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

What type(s) of caffeinated products do you typically consume?

- ☐ Caffeinated teas
- ☐ Carbonated beverages (e.g. soda, pop. Coke, etc.)
- ☐ Coffee
- ☐ Energy drinks
- ☐ Espresso
- ☐ Other

Please specify

_____

On a typical day, how many servings of these caffeinated products do you typically consume? One serving is 8 oz or 240 mL of coffee, tea, or energy drinks, 1 oz or 30 mL of espresso, 12 oz or 360 mL of soda

_____
(Number)

Today, have you had coffee or any other caffeinated products?

- ◯ Yes
- ◯ No

What type(s) of caffeinated products have you had today?

- ☐ Caffeinated teas
- ☐ Carbonated beverages (e.g. soda, pop. Coke, etc.)
- ☐ Coffee
- ☐ Energy drinks
- ☐ Espresso
- ☐ Other

Please specify

_____

How many servings of these caffeinated products have you had today?

_____
(Number)

Nicotine use

Have you ever used any of the following nicotine (tobacco) products? Please check all that apply.

- ☐ I have never used a nicotine product
- ☐ Cigarette or cigar
- ☐ Electronic nicotine product (e.g. e-cigarettes, vape pens, hookah pens, personal vaporizers, e-cigars, e-pipes, e-hookahs, etc.)
- ☐ Nicotine patch
- ☐ Nicotine gum or chew
- ☐ Other

Please specify

_____

Have you used any nicotine products at least 100 times in your entire life?

- ◯ Yes
- ◯ No
- ◯ Not certain
- ◯ Prefer not to answer

Do you currently use any nicotine products every day, some days, or not at all?	◯ Every day ◯ Some days ◯ Not at all ◯ Prefer not to answer
How old were you when you first started regularly using nicotine products?	◯ Age: Enter age ◯ Not certain ◯ Prefer not to answer
Age: Enter age	_____ (Number)
If you have completely stopped using nicotine, about how old were you when you stopped?	◯ Age when you stopped using: Enter age ◯ Not certain ◯ Prefer not to answer
Age when you stopped using: Enter age	_____ (Number)
For how many years have you used nicotine?	◯ Less than 1 year ◯ Number of years : Enter number ◯ Not certain ◯ Prefer not to answer
Number of years : Enter number	_____ (Number)
On average, how many times do you use nicotine per day now?	◯ Less than once per day ◯ Number of uses per day: Enter number ◯ Not certain ◯ Prefer not to answer
Number of uses per day	_____ (Number)
On average, over the entire time that you used nicotine, how many times each day did you use nicotine?	◯ Less than once per day ◯ Number of uses per day: Enter number ◯ Not certain ◯ Prefer not to answer
Number of uses per day: Enter number	_____ (Number)

Alcohol consumption

Do you drink alcohol?
(Drinks can be beer, wine, shots of liquor, cocktails containing a shot of liquor)

- ◯ Yes
- ◯ No
- ◯ Not currently, but I have in the past
- ◯ Prefer not to answer

How often do you have at least one drink containing alcohol?

- ◯ Monthly or less
- ◯ 2 - 4 times a month
- ◯ 2 - 3 times a week
- ◯ 4 or more times a week
- ◯ Prefer not to answer

How many drinks containing alcohol do you have on a typical day when you are drinking?
One drink is 12 oz. or 330 mL of beer, 5 oz. or 150 mL of wine, 1.5 oz. or 45mL (one shot) of liquor

- ◯ 2 or fewer
- ◯ 3 - 4
- ◯ 5 - 6
- ◯ 7 - 9
- ◯ 10 or more
- ◯ Prefer not to answer

How often did you have six or more drinks on one occasion in the past year?

- ◯ Never in the past year
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily
- ◯ Prefer not to answer

Have you drunk alcohol today?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

How many drinks have you had today?

_____
(Number)

Are you currently in recovery for alcohol use?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Have you ever been in rehab or counseling for heavy alcohol use?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Other Substance use

Have you ever used medicines ON YOUR OWN without a doctor's prescription, or in greater amounts or longer than prescribed?

- ◯ No
- ◯ Not this year, but I have in the past
- ◯ One or more times this year
- ◯ Prefer not to respond

Have you ever used marijuana, cocaine or crack, and/or other drugs?

- ◯ No
- ◯ Not this year, but I have in the past
- ◯ One or more times this year
- ◯ Prefer not to respond

In the PAST THREE MONTHS, how often have you SMOKED marijuana (e.g. cannabis, pot, grass, hash, weed, etc.) either recreationally or as prescribed by a doctor?

- ◯ None
- ◯ Once or twice
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily
- ◯ Prefer not to answer

In the PAST THREE MONTHS, how often have you taken marijuana as an EDIBLE either recreationally or as prescribed by a doctor?

- ◯ None
- ◯ Once or twice
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily
- ◯ Prefer not to answer

During the past TWO (2) WEEKS, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?

	Not at all	One or two days	Several days	More than half the days	Nearly every day
Painkillers (like Vicodin)	◯	◯	◯	◯	◯
Stimulants (like Ritalin, Adderall)	◯	◯	◯	◯	◯
Sedatives or tranquilizers (like sleeping pills or Valium)	◯	◯	◯	◯	◯
Marijuana	◯	◯	◯	◯	◯
Cocaine or crack	◯	◯	◯	◯	◯
Club drugs (like ecstasy)	◯	◯	◯	◯	◯
Hallucinogens (like LSD)	◯	◯	◯	◯	◯
Heroin or other opioids, including synthetic opioids like fentanyl	◯	◯	◯	◯	◯
Inhalants or solvents (like glue)	◯	◯	◯	◯	◯
Methamphetamine (like speed)	◯	◯	◯	◯	◯

Are you currently in recovery for substance use?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Have you ever been in rehab or counseling for heavy substance use?

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

Deprecated Fields

[DEPRECATED]
Hormone use

- ☐ Oral contraceptive
- ☐ Hormonal replacement therapy (HRT)
- ☐ Androgenic steroids
- ☐ Other

[DEPRECATED]
Do you currently take or use any of these medications or substances? Please check all that apply

- ☐ Antibiotics
- ☐ Anti-histamines (allergy medications)
- ☐ Anti-Hypertensive Medications (Blood Pressure Medication)
- ☐ Diuretics (ex: Lasix)
- ☐ Decongestants
- ☐ Muscle relaxants (ex: Baclofen)
- ☐ Hormone use
- ☐ Inhaled corticosteroids
- ☐ Oral steroids
- ☐ Anti-anxiety medications: (ex: Benzodiazepine)
- ☐ Chronic Pain medication
- ☐ Psychotropic/antipsychotic medications (ex: Clozapine)
- ☐ Antidepressants (ex: amitryptiline)
- ☐ Immune suppressors (ex: Methotrexate)
- ☐ Reflux medications (ex: Pantoprazole, Nexium)
- ☐ Anticholinergics (ex: Ventolin)
- ☐ Anticoagulants (blood thinners)
- ☐ Antiepileptic (ex: Phenytoin)

[DEPRECATED]
Chronic Pain medication

- ☐ NSAIDs (ex: Ibuprofen/Advil/Cerebrex)
- ☐ Morphine/Oxycodone
- ☐ Neuro-modulators (ex: Gabapentin, Lyrica)

[DEPRECATED]
There are some symptoms that can affect your voice. Are you currently experiencing any of these symptoms? Check all that apply.

- ☐ Anxiety or nervousness
- ☐ Confusion
- ☐ Dizziness
- ☐ Frequent or severe headache or migraine
- ☐ Sleep disturbance
- ☐ Speech difficulty
- ☐ Prefer not to answer

[DEPRECATED]
Do you do one of these jobs or hobbies that requires using your voice for many hours a day? Check all that apply

- ☐ Bartender
- ☐ Waiter, receptionist
- ☐ Speaking (secretary, call center, attorney, salesperson)
- ☐ Teacher
- ☐ Singer
- ☐ Cheerleading
- ☐ Other

[DEPRECATED]
Have you smoked at least 100 cigarettes in your entire life? (There are 20 cigarettes in a pack.)?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

[DEPRECATED]
Do you now smoke cigarettes every day, some days, or not at all?

- ◯ Every day
- ◯ Some days
- ◯ Not at all
- ◯ Don't know
- ◯ Prefer not to answer

[DEPRECATED]
How old were you when you first started regular cigarette smoking?

- ◯ Specify
- ◯ Don't know
- ◯ Prefer not to answer

[DEPRECATED]
Age: _____

[DEPRECATED]
If you have completely stopped smoking cigarettes, about how old were you when you stopped?

◯ Specify
◯ Don't know
◯ Prefer not to answer

[DEPRECATED]
Age when you stopped smoking:

_____

[DEPRECATED]
How many years have you or did you smoke cigarettes?

◯ Specify
◯ Don't know
◯ Prefer not to answer

[DEPRECATED]
Number of years:

_____

[DEPRECATED]
On average, how many cigarettes do you smoke per day now? (There are 20 cigarettes in a pack.)

◯ Specify
◯ Don't know
◯ Prefer not to answer

[DEPRECATED]
Number of cigarettes per day:

_____

[DEPRECATED]
On average, over the entire time that you smoked, how many cigarettes did you smoke each day? (There are 20 cigarettes in a pack.)

◯ Specify
◯ Don't know
◯ Prefer not to answer

[DEPRECATED]
Number of cigarettes per day:

_____

[DEPRECATED]
In the PAST THREE MONTHS, how often have you used marijuana (cannabis, pot, grass, hash, etc.)?

◯ Never
◯ Once or twice
◯ Monthly
◯ Weekly
◯ Daily or almost daily
◯ Prefer not to answer

[DEPRECATED]
Have you ever used an electronic nicotine product, even one or two times?
(Electronic nicotine products include e- cigarettes, vape pens, hookah pens, personal vaporizers and mods, e-cigars, e-pipes, and e-hookahs.)

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

[DEPRECATED]
Do you now use electronic nicotine products?

◯ Every day
◯ Some days
◯ Not at all
◯ Don't know
◯ Prefer not to answer

[DEPRECATED]
Have you been a regular smoker or not within the last 3 years?

◯ Yes
◯ No

[DEPRECATED]
Have you ever smoked regularly (more than a few times a month for at least two months)?
This includes tobacco, cannabis, vapes, e-cigarettes, hookah, or pipes.

◯ I've never smoked regularly
◯ I used to smoke
◯ I currently smoke
◯ Prefer not to answer

[DEPRECATED]
At what age did you start smoking? _____

[DEPRECATED]
At what age did you stop? _____

[DEPRECATED]
Checklist of different types (choose all that apply):
- ☐ Tobacco cigarettes
- ☐ Cannabis joints, bong, pipe
- ☐ Vapes
- ☐ e-cigarettes
- ☐ Hookah
- ☐ Pipes
- ☐ Other
- ☐ Prefer not to answer

[DEPRECATED]
How often do/did you smoke?
- ◯ Multiple times a day
- ◯ About once a day
- ◯ A few times a week
- ◯ A few times a month
- ◯ A few times a year
- ◯ Prefer not to answer

[DEPRECATED]
If you selected "other" for smoking type, please specify: _____

[DEPRECATED]
How often do you have at least one drink containing alcohol?
- ◯ Monthly or less
- ◯ 2 - 4 times a month
- ◯ 2 - 3 times a week
- ◯ 4 or more times a week
- ◯ Prefer not to answer

[DEPRECATED]
How many drinks containing alcohol do you have on a typical day when you are drinking?
One drink is 12 oz. or 330 mL of beer, 5 oz. or 150 mL of wine, 1.5 oz. or 45mL (one shot) of liquor
- ◯ 2 or fewer
- ◯ 3 - 4
- ◯ 5 - 6
- ◯ 7 - 9
- ◯ 10 or more
- ◯ Prefer not to answer

[DEPRECATED]
Have you drunk alcohol today?
- ◯ Yes
- ◯ No

[DEPRECATED]
Are you currently in recovery for alcohol use?
- ◯ Yes
- ◯ No

[DEPRECATED]
Have you ever been in rehab or counseling for heavy alcohol use?
- ◯ Never in the past year
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily
- ◯ Prefer not to answer

[DEPRECATED]
How many times in the past YEAR have you used a recreational substance or medication for reasons or in doses other than prescribed?
Recreational substances include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).
More than one

◯ Yes
◯ No

[DEPRECATED]
Are you currently in recovery for substance use?

◯ Yes
◯ No

[DEPRECATED]
Do you have any dental problems that might affect speech?

◯ Yes
◯ No

[DEPRECATED]
Do you currently have any tooth loss, dentures, retainers or braces?

_____

[DEPRECATED]
Do you currently have seasonal allergies, cold-like symptoms or other conditions that may affect your voice today?

◯ Yes
◯ No

[DEPRECATED]
Check all that apply:

☐ Nasal congestion or obstruction
☐ Cough
☐ Scratchy or sore throat
☐ Shortness of breath

[DEPRECATED]
Ear

☐ Chronic ear infection
☐ Cochlear implant
☐ Hearing loss

[DEPRECATED]
Nose

☐ Frequent sinusitis

[DEPRECATED]
Throat

☐ Pre-cancerous throat lesion (e.g. laryngeal leukoplakia or keratosis
☐ Reflux (heartburn)
☐ Reinke's edema, polypoid corditis, or smoker's larynx
☐ Sjögren's syndrome
☐ Swallowing disorders (dysphagia)
☐ Throat cancer
☐ Thyroid disease
☐ Velopharyngeal insufficiency
☐ Vocal fold dysfunction, paradoxical vocal fold motion, or inducible laryngeal obstruction
☐ Vocal fold polyp, nodule, or cyst
☐ Vocal hemorrhage or bleed
☐ Voice/throat disorder

[DEPRECATED]
Head

☐ Radiation around head and neck
☐ Seasonal allergies

[DEPRECATED]
Ear

☐ Chronic ear surgery (e.g. mastoid)
☐ Ear tubes

[DEPRECATED] Nose	☐ Septoplasty/Rhinoplasty ☐ Sinus surgery
[DEPRECATED] Throat	☐ Airway surgery ☐ Throat surgery ☐ Thyroid surgery ☐ Tonsillectomy/Adenoidectomy
[DEPRECATED] Head	☐ Head/Neck cancer (e.g. oropharyngeal cancer) ☐ Sleep surgery
[DEPRECATED] Neurological Medical History	☐ Brain tumor ☐ Dysarthria ☐ Epilepsy ☐ Multiple sclerosis ☐ Traumatic brain injury ☐ Other
[DEPRECATED] Do you currently have these conditions or currently experience symptoms as a result of having had these conditions?	◯ None ◯ Only some ◯ All
[DEPRECATED] Which ones do you currently have?	_____
[DEPRECATED] Respiratory Conditions	☐ Bronchiectasis ☐ Cancer (lung or metastatic) ☐ Emphysema ☐ Interstitial lung disease (sarcoidosis, pulmonary fibrosis) ☐ Pneumothorax or atelectasis (collapsed lung) ☐ Pulmonary hypertension ☐ Radiation to the chest ☐ Tuberculosis
[DEPRECATED] Cancer (lung or metastatic)	☐ Lung ☐ Metastatic
[DEPRECATED] Have you had COVID recently, or are you currently experiencing the effects of long COVID? (check all that apply)	☐ COVID in the past year ☐ Long COVID (symptoms persisted at least four weeks after initial infection)
[DEPRECATED] Have you had COVID in the past month?	◯ Yes ◯ No
[DEPRECATED] Are you currently using CPAP or supplemental oxygen? (check all that apply)	☐ Active CPAP use ☐ On supplemental oxygen
[DEPRECATED] Respiratory medical history	☐ Craniofacial or chest wall trauma ☐ Previous lobectomy ☐ Prior chest/airway surgery ☐ Prolonged intubation (more than a week)
[DEPRECATED] Have you been exposed to environmental pollution that may affect your breathing or voice?	◯ Yes ◯ No

[DEPRECATED] Are you having difficulty breathing today?	◯ Yes ◯ No
[DEPRECATED] Please specify the level of difficulty	◯ Slight Difficulty ◯ Moderate Difficulty ◯ Significant Difficulty
[DEPRECATED] Are you coughing today?	◯ Yes ◯ No
[DEPRECATED] What is the severity of your cough?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
[DEPRECATED] Have you been diagnosed with any of these circulatory or heart conditions by a clinician? (check all that apply)	☐ Atrial fibrillation ☐ Cardiac condition ☐ Chronic pericarditis ☐ Congestive heart failure ☐ Coronary heart disease ☐ Hypertension
[DEPRECATED] Cardiac condition	_____
[DEPRECATED] Some other conditions can affect the sound of your voice. Have you been diagnosed with any of these conditions by a clinician? (check all that apply)	☐ Chronic kidney disease ☐ Diabetes ☐ Infectious disease ☐ Obesity ☐ Scoliosis
[DEPRECATED] Infectious disease	_____