Speech & Voice Experience

Swallowing Case History
Adult

Please fill out this form as completely as possible. If you need more space, attach another page.

Thank you for taking the time to fill out these forms. Complete case history forms are essential to receiving a thoughtful and well-designed evaluation. By sending these completed forms to our office at least TWO DAYS PRIOR to your appointment, we are able to best determine how to maximize our time with you. We look forward to meeting you.

I. GENERAL INFORMATION

Date:_____

Patient Name: _____ Date of Birth: _____

Address:_____ City, State, Zip:_____

Email Address:_____ Phone:_____

Primary Care Physician:_____ Phone: _____

Address:_____ Fax: _____

_____ Email: _____

Referring Physician (if different):_____ Phone: _____

Address:_____ Fax: _____

_____ Email: _____

Occupation(s):_____ ☐Part time ☐Full-time ☐Unemployed ☐Retired ☐Disabled

_____ ☐Part time ☐Full-time ☐Unemployed ☐Retired ☐Disabled

Patient Height: _____ Patient Weight: _____

II. HISTORY OF THE PROBLEM

1. Do you cough or choke while eating or just after a meal? ☐Yes ☐No If yes, please describe the nature and frequency of the problem. _____

   _____

2. Does it take multiple swallows to get food down? ☐Yes ☐No
3. When did the swallowing problem begin? _____
4. Were there any events or conditions with which you can associate the onset of your symptoms?
   ☐Yes ☐No If yes, please explain._____

   _____

5. Have your swallowing difficulties changed since you first noticed them?
   ☐Yes ☐No If yes, please explain._____

   _____

6. Have you had the same or similar problems in the past? ☐Yes ☐No If yes, please explain. _____

   _____

7. Have you been to any specialists in relation to these symptoms? ☐Yes ☐No If so, whom have you seen? _____

Patient Name: _____ Date of Birth: _____

8. Have you ever had a barium swallow study or a modified barium swallow study? ☐Yes ☐No
   If so, when? _____
9. Have you ever undergone FEES (Fiberoptic Evaluation of Swallowing)? ☐Yes ☐No
10. List any other referrals or recommendations that have been made: _____
    _____
11. Have you ever received swallow therapy in the past? ☐Yes ☐No
    If yes, When: _____
    Duration: _____
    Therapist Name: _____
    Please give a brief description of what you did in therapy: _____
    _____
12. Have you ever had pneumonia? ☐Yes ☐No If yes please list dates: _____
    _____
13. How long does it take to finish a meal? _____

III. MEDICAL HISTORY

1. Please check any conditions you currently have or have had in the past:

☐ High blood pressure	☐ Myasthenia Gravis	☐ Aids or other immunologic disorder
☐ Low blood pressure	☐ Parkinson's Disease	☐ Cancer
☐ Heart disease	☐ Multiple Sclerosis	☐ Syphilis
☐ Stroke	☐ ALS (Lou Gehrig's Disease)	☐ Medically diagnosed depression
☐ Heart Attack	☐ Seizures	☐ Sinus problems/Sinusitis
☐ Tuberculosis	☐ Meningitis	☐ Cleft Palate
☐ Asthma	☐ Lupus	☐ Head Injury
☐ Bronchitis	☐ Diabetes	☐ Whiplash
☐ Pneumonia	☐ Thyroid Disease	☐ Injury to neck or chest
☐ COPD	☐ Endocrine Disorder	☐ Ulcers
☐ Kidney Disease	☐ Hypoglycemia	☐ Gastroesophageal reflux
☐ Urinary Problems	☐ Arthritis	☐ Hiatal hernia
☐ Other: _____		☐ NONE

2. Indicate other medical procedures you have had (check all that apply):

☐ Tonsillectomy	☐ Oral Surgery	☐ Thyroid Surgery
☐ Adenoidectomy	☐ Tracheotomy	☐ Radiation (Specify: _____)
☐ Appendectomy	☐ Lung Surgery	☐ Other (Specify: _____)
☐ Heart Surgery	☐ Hysterectomy	☐ NONE

Patient Name: _____ Date of Birth: _____

IV. FAMILY QUESTIONS, CONCERNS, AND GOALS **(Please use reverse side if additional space is needed)**

1. What specific questions do you have that you would like us to try to answer?

2. Are there any concerns regarding the swallowing evaluation? _____

3. What goals would you like to see accomplished as a result of this evaluation? _____

4. Please share any other information that you believe we need to know prior to the evaluation: _____