Adult Swallowing Case History

Please fill out this form as completely as possible and send these forms to our office TWO DAYS prior to your evaluation. If you need more space, attach another page. We look forward to meeting you.

I. GENERAL INFORMATION Date:_____

Patient Name:_____ Date of Birth:_____

Patient Email Address:_____

Primary Care Physician:_____ Phone:_____

Address:_____ Fax:_____

_____

Referring Physician (if different):_____ Phone:_____

Address:_____ Fax:_____

_____

Occupation(s):_____Part time/full time/unemployed/retired/disabled?

_____Part time/full time/unemployed/retired/disabled?

II. HISTORY OF THE PROBLEM

1. Do you cough or choke while eating or just after a meal? If yes, please describe the nature and frequency of the problem?_____

   _____

2. Does it take multiple swallows to get food down?_____

   _____

3. When did the swallow problem begin? Were there any events or conditions with which you can associate the onset of your symptoms?_____

_____

_____

4. Have your swallowing difficulties changed since you first noticed them?_____

   _____

5. Have you had the same or similar problems in the past?_____

   _____

6. Have you been to any specialists in relation to these symptoms? If so, whom have you seen?_____

   _____

7. Have you ever had a barium swallow study or a modified barium swallow study? If so, when?_____
8. List any other referrals or recommendations that have been made:_____

   _____

9. Have you ever received swallow therapy in the past?

   When_____

   Duration _____

   Therapist Name_____

   Please give a brief description of what you did in therapy?_____

   _____

10. Have you ever had pneumonia? If yes please list dates: _____
11. How long does it take to finish a meal? _____

IV. MEDICAL HISTORY

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

___ High blood pressure	___ Myasthenia Gravis
___ Low blood pressure	___ Parkinson's Disease
___ Heart disease	___ Multiple Sclerosis
___ Stroke	___ ALS (Lou Gherig's Disease)
___ Heart attack	___ Seizures
___ Tuberculosis	___ Meningitis
___ Asthma	___ Lupus
___ COPD	___ Diabetes
___ Kidney Disease	___ Endocrine Disorder
___ Urinary problems	___ Thyroid Disease
___ Head injury	___ Hypoglycemia

___ Whiplash
___ Injury to neck or chest
___ Sinusitis
___ Depression
___ Reflux
___ Cleft Palate
___ Frequent upset stomach
___ Confusion
___ Memory change
___ Frequent headaches
___ Tremor
___ Insomnia
___ Other (Please specify)_____

___ Arthritis
___ AIDS or immunologic disorder
___ Cancer
___ Syphilis
___ Hiatal Hernia
___ Hearing loss
___ Night coughing that interrupts sleep
___ Heartburn
___ Pain in body, where?_____
___ Nasal regurgitation
___ Shortness of breath
___ Anxiety

2. Please indicate any medical procedures you have had:

___ Tonsillectomy
___ Adenoidectomy
___ Appendectomy
___ Oral surgery
___ Heart surgery
___ Other (Specify)_____

___ Tracheotomy
___ Lung Surgery
___ Chemotherapy (When?)_____
___ Thyroid surgery
___ Radiation (Specify)_____