Stony Brook Medicine

ADULT SPEECH PATHOLOGY
SWALLOWING HISTORY FORM

Name: _____
Date of Birth: _____

Reason for this evaluation: _____
Previous Swallow Evaluation: □ No □ Yes □ Stony Brook □ Other: _____

Past Medical History – please provide date of onset for any YES responses

Anxiety/Depression	□YES	□NO	Laryngitis	□YES	□NO
Autism	□YES	□NO	Learning Disability	□YES	□NO
ADD/ADHD	□YES	□NO	Lung Cancer	□YES	□NO
Asthma/COPD	□YES	□NO	Mental Retardation	□YES	□NO
Allergies	□YES	□NO	Oral/Tonsil Cancer	□YES	□NO
Brain Cancer	□YES	□NO	Pneumonia	□YES	□NO
Bronchitis	□YES	□NO	Radiation Therapy	□YES	□NO
Cardiac Disease	□YES	□NO	Shortness of breath	□YES	□NO
Chemotherapy	□YES	□NO	Seizures	□YES	□NO
Cerebral Palsy	□YES	□NO	Sleep Apnea	□YES	□NO
Cleft Palate	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Dementia	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Diabetes	□YES	□NO	Swallowing Problems	□YES	□NO
Gastric Reflux	□YES	□NO	Surgery	□YES	□NO
Head/Neck Cancer	□YES	□NO	□ Cancer □ Head & Neck □ Other: _____		
Head/Neurological Injury	□YES	□NO	Thyroid Cancer	□YES	□NO
Hearing Loss	□YES	□NO	Tracheostomy tube	□YES	□NO
High Blood Pressure	□YES	□NO	Thyroid Disease	□YES	□NO
Kidney Disorder	□YES	□NO	Visual Impairment	□YES	□NO
Leukemia	□YES	□NO	Voice Impairment	□YES	□NO
			Ventilator Dependency	□YES	□NO

How do you take Medication? □ With water □ In puree □ Other: _____
List medications or attach list:

Please check any of the following specialists seen in past: □ Physical or Occupational Therapist
□ Ear Nose and Throat Specialist □ Eye Specialist □ Neurologist □ Psychiatrist/Psychologist □ Pulmonologist
□ Cardiologist □ Neuropsychologist □ Speech/Language Pathologist □ Audiologist (Hearing Test)

Family and Social History: Please check all that apply
□ Working □ Student □ Unemployed □ Retired □ Live alone □ Tobacco user d/c date: _____
□ Alcohol use ___/day □ Recreational drug use

Swallowing problem: □ Gradual Onset □ Sudden Onset □ Past few weeks □ Past few months □ 6-12 months
□ Over ____ years □ Improved over time □ Gotten worse over time □ Stayed the same over time

Current diet/nutrition/hydration: Check all that apply □ Feeding tube □ Regular □ Cut up/soft foods
□ Finely chopped □ Puree □ Thin liquids □ Slightly thick liquids □ Nectar thick liquids □ Honey thick liquids
□ Good appetite □ Fair appetite □ Poor appetite □ Recent weight loss - __# of lbs. over ___ weeks/mos.
□ Food allergies: _____ □ Other: _____
_____# meals/feedings per day Length of meal time: _____ minutes □ Assistance with meals

 Reviewed by SBUH SLP _____
Initials

Name: _____
Date of Birth: _____

Describe any management strategies you are using to swallow: _____
_____

Do you wear dentures? □ No □Yes Circle: Upper / Lower / Partial
Current physical status: □ Walk independently □ Walker □ Cane □ Wheelchair
Please describe your voice: □Normal □ Hoarse □Breathy □Weak □ No voice

Do you experience any of the following? (Check all that apply)

□ Poor morning voice quality
□ Frequent throat clearing
□ Increased phlegm in the throat
□ Tastes repeating after meals
□ Increased throat/mouth dryness
□ Frequent burping
□ Feeling of throat tightness
□ Throat soreness or burning sensation not related to illness
□ Coughing episodes not related to illness/swallowing
□ Heartburn (If checked, how many times per week? ____)
□ Feeling of a lump in the throat when swallowing
□ Bad taste in the mouth (sour, acidic, metallic)
□ Unpredictable/variable voice quality during the day
□ Increased coughing when lying down

Additional Information:
_____
_____
_____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Reviewed by SBUH SLP_____ _____
Name/ ID number **date/time**

SLP Notes: