Stony Brook Medicine

ADULT SPEECH PATHOLOGY
COMMUNICATION HISTORY FORM

Name: _____
Date of Birth: _____

Reason for evaluation: □ Slurring Sounds when Speaking □ Difficulty Retrieving Words □ Memory/Attention
□ Difficulty Understanding Others □ Groping for Sound when Speaking □ 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 □ Neurosurgeon □ Psychiatrist/Psychologist
□ Pulmonologist □ Cardiologist □ Neuropsychologist □ Speech/Language Pathologist □ Audiologist/Hearing

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

Onset date of communication difficulty: _____ □ Gradual onset □ Sudden onset
Did communication concern follow an illness/family problem/traumatic event? □ NO □ YES
If yes, please explain: _____
Has it changed over time? □ NO □ YES: □ Worse □ Better
Able to read/understand: □ Words □ Sentences □ News articles □ Books
Current Communication: □ Speech □ Writing □ Gestures □ Communication Board
Trouble hearing: □ NO □ YES: □ Hearing Aids
Voice change: □ NO □ YES: □ Hoarse □ Breathy □ Strained □ Too Soft □ Other: _____

 Reviewed by SBUH SLP _____
Initials

Name: _____
Date of Birth: _____

Additional Information:
_____
_____
_____

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

Name Address or Fax Phone
_____
_____
_____
_____

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers

_____

Name	Relationship to patient	Address	Phone	Fax

_____

Name	Relationship to patient	Address	Phone	Fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.

Signature of □Patient □Parent/Guardian _____ Date: _____
Printed name of Parent/Guardian: _____

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

SLP Notes: