Stony Brook Medicine

PEDIATRIC SPEECH PATHOLOGY
SPEECH RESONANCE HISTORY FORM

Name: _____
Date of Birth: _____

Reason for evaluation: □ Nasal speech □ Reduced speech intelligibility □ Other: _____

Pregnancy/Birth History (check all that apply): □ Full term □ Preterm: _____ weeks gestation
Pregnancy: □ Uncomplicated □ Complicated: □ Tobacco/alcohol/drug use □ Other_____
□ Birth Complications: □ Breathing Problems □ Feeding Problems □ NICU

History of Cleft: □ No □ Yes: Lip: □ Left □ Right □ Complete □ Incomplete Date of Repair: _____
Palate: □ Left □ Right □ Hard and Soft Palate □ Soft Palate □ Submucus Date of Repair: _____
□ Pharyngoplasty □ Pharyngeal Flap □ Other Related Surgeries: _____

Developmental History:

Sitting/walking:	□ Within Normal Limits	□ Delayed Development
Trained for bowel/bladder:	□ Within Normal Limits	□ Delayed Development
Bottle/breast/spoon feeding:	□ Within Normal Limits	□ Delayed Development
Chewing solids:	□ Within Normal Limits	□ Delayed Development
Control of saliva/drool:	□ Within Normal Limits	□ Delayed Development
Speech production/understanding:	□ Within Normal Limits	□ Delayed Development

Therapy history: □ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Feeding Therapy
Current Speech Therapy: _____#/week □ Individual □ Group
Current Educational Setting: □ Early Intervention/Dev. Program □ Preschool □ K-12 □ Special Ed. Class
Current Diet: _____ Liquid escapes into nose when drinking: □ Yes □ No
Bottle/Pacifier Use: □ No □ Yes - discontinued (date): _____

Past Medical History

Anxiety/Depression	□YES	□NO	Kidney Disorder	□YES	□ NO
Autism	□YES	□NO	Learning Disability	□YES	□NO
ADD/ADHD	□YES	□NO	Leukemia	□YES	□NO
Asthma/COPD	□YES	□NO	Intellectual Dev. Delay	□YES	□NO
Allergies	□YES	□NO	Pneumonia	□YES	□NO
Brain Cancer	□YES	□NO	Radiation Therapy	□YES	□NO
Bronchitis	□YES	□NO	Seizures	□YES	□NO
Cardiac Disease	□YES	□NO	Shortness of breath	□YES	□NO
Cleft Palate	□YES	□NO	Sleep Apnea	□YES	□NO
Cerebral Palsy	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Cancer	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Chemotherapy	□YES	□NO	Swallowing Problems	□YES	□NO
Diabetes	□YES	□NO	Surgery:	□YES	□NO
Gastric Reflux	□YES	□NO	_____		
Head/Neurological Injury	□YES	□NO	Tracheostomy tube	□YES	□NO
Hearing Loss	□YES	□NO	Tongue tie	□YES	□NO
Voice Impairment	□YES	□NO	Ventilator Dependency	□YES	□NO
Visual Impairment	□YES	□NO			

List medications or attach list:

 Reviewed by SBUH SLP _____

Name: _____
Date of Birth: _____

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

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: