Stony Brook Medicine

NAME:_____
Date of Birth _____

HEAD AND NECK CASE HISTORY ATTACHMENT

Diagnosis (date/type) _____
Physician name and location: _____

Surgery: □ No □ Yes □Completed □Planned Date/Type:_____
Radiation therapy: □ No □ Yes □Date Completed_____ □Date Planned_____
Chemotherapy: □ No □ Yes □Date Completed_____ □Date Planned_____

Current respiratory status: □ No difficulty □ Oxygen use □ Stoma (open hole in neck)
□ Trach tube (size and date placed) #_____

Dry Mouth: □ NO □ YES If yes, how do you manage it? _____
_____

Mucus/phlegm difficulty? □ NO □ YES If yes, how do you manage it?_____
_____

Current nutritional status?
Oral diet: □ Regular □ Cut up or soft solids □ Pureed □ Liquids only
Liquids: □ Regular/thin □ Nectar □ Honey
Tube feeding: □ NO □ YES amount and type:_____

Weight loss: □ NO □ YES **If yes, how many lbs._____, over_____weeks / months**

Any change in voice: □ NO □ YES **If yes, please circle all that apply:** hoarse breathy too soft strained loss of voice
Current communication: □ Speech □ writing □ Electrolarynx
□ Gestures □ Communication/letterboard

Previous speech or swallowing evaluations/treatments: □ NO □ YES
Date, name, location and phone number:_____
_____

Please write down any other information that you feel would be important for us to know:
_____
_____
_____

Speech Pathologist's notes:
_____
_____
_____