Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

PS3598

PLEASE PRINT

Patient's Name: _____ **DOB:** _____
Address: _____
Preferred Contact Phone #: _____ **2nd Contact Phone #:** _____
Who is filling out this form: _____ **Relationship to patient:** _____

Describe the swallowing problem: _____

- Onset of swallowing problem: ❑ Gradual ❑ Sudden ❑ Past few weeks ❑ Past few months ❑ 6 - 12 months ❑ Over ____ years
- Has the problem changed over time? ❑ Improved ❑ Gotten worse ❑ Same
- Have you received previous swallowing evaluations and/or treatment? ❑ No ❑ Yes
  If yes, list dates, name, location and phone number (if available):

Please describe the consistency of foods and liquids you are currently eating:
❑ Regular/ solid foods ❑ Cut up or soft foods ❑ Finely chopped ❑ Puree ❑ Thin liquids
❑ Nectar thick liquids ❑ Honey thick liquids
❑ Other: _____

Do you have a feeding tube? ❑ No ❑ Yes (date placed): _____
Amount/type of feeding per day:

- Have you had a recent weight loss? ❑ No ❑ Yes __ # of lbs. over __ weeks/ mos.
- Describe your appetite: ❑ Good ❑ Fair ❑ Poor
- Do you have dietary restrictions or eliminated any foods from your diet? ❑ No ❑ Yes (Please state restrictions) _____
- Food Allergies ❑ No ❑ Yes _____

Please describe any management strategies you are using to swallow your current diet:

- Length of meal time: ❑ < 20 minutes ❑ 20 - 30 minutes ❑ > 30 minutes
- Do you require any assistance with your meals? ❑ No ❑ Yes (describe)
- Do you wear dentures? ❑ No ❑ Yes Circle: Upper/ Lower/ Partial
- What is your current physical status? ❑ Walk independently ❑ Cane ❑ Wheelchair ❑ Walker
- Can you support: your upper body? ❑ No ❑ Yes Head? ❑ No ❑ Yes
- Please describe your voice: ❑ Normal ❑ Hoarse ❑ Breathy ❑ Weak ❑ No voice

ADULT SPEECH-LANGUAGE PATHOLOGY SWALLOWING CASE HISTORY

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

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

MEDICAL HISTORY: Please circle as follows:
P=In the past C=Current diagnosis/problem

- ❑ P ❑ C Reflex
- ❑ P ❑ C Ear Infections
- ❑ P ❑ C Gastritis
- ❑ P ❑ C Pneumonia
- ❑ P ❑ C High Blood Pressure
- ❑ P ❑ C Choking
- ❑ P ❑ C Diabetes
  (Insulin____?)
  (Meds_____?)
- ❑ P ❑ C Seizures
- ❑ P ❑ C Meningitis
- ❑ P ❑ C Hearing Loss
- ❑ P ❑ C Heart Attack
- ❑ P ❑ C Pacemaker
- ❑ P ❑ C COPD
- ❑ P ❑ C Memory Loss
- ❑ P ❑ C Headaches
- ❑ P ❑ C Head Injury
- ❑ P ❑ C Depression
- ❑ P ❑ C Dizziness
- ❑ P ❑ C Anxiety
- ❑ P ❑ C Unintentional Weight Loss
- ❑ P ❑ C Stroke
- ❑ P ❑ C Asthma
- ❑ P ❑ C High Cholesterol
- ❑ P ❑ C Influenza
- ❑ P ❑ C Cancer (details:)

_____
_____
_____

Dates & types of past or recent surgeries _____
_____

Outpatient Medication History: Include ALL prescription, over the counter, supplements and herbal products.
If more room is needed, please use back side of this form.

Medication	Dosage	# Times Taken/Day	Reason for taking

Allergies _____

Please add any additional information you feel may help to further understand swallowing difficulty: _____
_____

Please list name & numbers of those doctors you want report to be faxed to: _____
_____

Patient's Name (Print) _____ **Signature** _____ **Date** _____ **Time** _____

NYS licensed Speech-Language Pathologist's Signature _____ **Date** _____ **Time** _____

(Print Name) _____

ADULT SPEECH-LANGUAGE PATHOLOGY SWALLOWING CASE HISTORY

Medications Continued

Medication	Dosage	# Times Taken/Day	Reason for taking