Stony Brook Medicine

Adult Swallowing Case History Attachment

Name: _____

Please describe the swallowing problem:_____
_____

Onset of swallowing problem: (date if known) _____
□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: _____
_____

Please describe the consistency of foods and liquids you are currently eating:
□Regular foods □ Cut up or soft foods □ Finely chopped □ Puree
□Thin liquids □ Nectar thick liquids □ Honey thick liquids
□ Other_____

How do you take Medication? _____
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 have you eliminated any foods from your diet?
□No □ Yes (Please state restrictions) _____

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

Length of meal time: □ < 20 minutes □20 - 40 minutes □> 40 minutes
Do you require any assistance with your meals? □NO □ YES (describe) _____
_____
How often do you cough, choke, or throat clear when eating or drinking?
□never □ several times per week □ daily □ several times per day

When eating or drinking, do you have the sensation of food "stuck in your throat?" □ No □Yes (describe) _____
Do you experience reflux/heartburn? □ No □Yes Medication/dose:_____
Do you wear dentures? □ No □Yes Circle: Upper / Lower / Partial
What is your current physical status? □ Walk □ Cane □ Wheelchair
Can you support: your upper body? □No □ Yes **head?** □ No □Yes
Please describe your voice: □Normal □ Hoarse □Breathy □Weak □ No voice