



Form ID:

Rev:

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SWALLOWING CASE HISTORY

Legal Name: _____ **Date:** _____

Preferred Name: _____

Pronouns: she/her/hers he/him/his they/them/theirs Other (please specify): _____

Birthdate: _____ **Phone:** _____

Alternate Phone (if desired): _____

E-mail address: _____

Main Language Spoken: English Other (specify): _____

Alternate Contact Person (if desired): _____

Family Doctor: _____

Current Medications:

Relevant Medical History (check/list all that apply):

Headache Diabetes Dizziness Hypertension Encephalitis

Respiratory Issues Pneumonia Cardiac Issues Seizures Reflux

Head Injury - Date(s): _____ Stroke - Date(s): _____

Other: _____

Allergies/Sensitivities: _____

Hearing Aids? Yes No Left Right Both ears In the ear Outside the ear

Glasses? Yes No For reading For distance Bifocals

Dentures? Yes No Uppers Lower Plate Other _____

1. Please describe your swallowing difficulty: _____

2. When did this difficulty begin? _____

3. Are your swallowing problems related to other medical problems? _____

4. Have you been seen by a physician for this specific difficulty? Yes No

Family Doctor ENT Neurologist Gastroenterologist

Physician Name(s): _____

Date(s) seen: _____

5. Do you avoid certain foods? _____

6. Does your food require special preparation? _____

7. Is there anything that makes your problem better or worse? _____

8. Do you experience the following during/after eating or drinking:

Coughing Yes No

Choking Yes No

Food/fluid going "the wrong way" Yes No

Food in your mouth after a meal Yes No

Food/fluid falling from mouth Yes No

Fluid coming up through nose Yes No

Food "stuck" in your throat Yes No

Heartburn Yes No

9. Do you have changes to voice/speech? Yes No

If yes, please describe: _____

10. Have you recently had pneumonia? Yes No Date: _____

11. Have you had recent weight loss? Yes No