

Name: _____ DOB: _____ AGE: _____

Primary Doctor: _____ Referring Doctor (If different): _____

MEDICAL HISTORY (Check if Applicable)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cardiac Bypass Surgery | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Change in Voice or Speech |
| <input type="checkbox"/> Anterior Cervical Fusion | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Chronic Dry Mouth |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Previous Swallowing Exam or Therapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma or COPD | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Pneumonias | <input type="checkbox"/> Intubation / # of Days |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dehydration/Malnutrition | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Cancer (state type) | <input type="checkbox"/> ALS | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease/Surgery | |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Esophageal Stretching | |

If any Radiation Treatment, to what part of the body? _____

Describe your swallowing difficulty (be as detailed as possible):

How long has this been going on? _____

How do you take your pills? _____

Any trouble swallowing pills? YES NO

Which do you have the most difficulty? Solids Liquids Both Solids and Liquids

About how long does it take you to eat a meal? _____

Do you have any of the following? If so please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Interrupted Sleep | <input type="checkbox"/> Acidic, Metallic or Sour taste in back of throat or mouth | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Spasms of the Throat or Voice Box |
| <input type="checkbox"/> Lightheaded or Faint | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Pain inside mouth |
| <input type="checkbox"/> Regurgitation of Undigested Food | <input type="checkbox"/> Belching or Hiccuping | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Choking Sensation | <input type="checkbox"/> Chronic Asthma |
| <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Loss of Voice |
| <input type="checkbox"/> Repeated Swallowing | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Aspiration (the entry of foreign material or secretions into the airway) |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Dry or Sore Throat | |
| | <input type="checkbox"/> Increased Salivation | |

Within the last MONTH, how did the following problems affect you?	0 = No Problem 5 = Severe Problem					
	1. Hoarseness or a problem with your voice	0	1	2	3	4
2. Clearing your throat	0	1	2	3	4	5
3. Excess throat mucous or post nasal drip	0	1	2	3	4	5
4. Coughing after you ate or lying down	0	1	2	3	4	5
5. Breathing difficulties or choking episodes	0	1	2	3	4	5
6. Sensation of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
7. Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Anything else in your background, or why you were referred that you think we should know to better evaluate you?

Thank You!

Questions? Please call:

University of Maryland Upper Chesapeake Medical Center: 443-643-3257

University of Maryland Harford Memorial Hospital: 443-843-5331