SPEECH THERAPY
SWALLOWING EVALUATION CASE HISTORY QUESTIONNAIRE

Patient: **Date of Service:**

Primary Care Physician: **Referring Physician:**

Diagnosis:

Medical History (Include surgeries):

Question	YES	NO	Comments
Have you ever been diagnosed with any neurological conditions?			
Have you ever had pneumonia? If so, how often & when was last episode?			
Have you ever had a swallow evaluation before? If so, for what reason, when and where? What were recommendations?			
Have you ever had radiation?			

Chief Complaint (Describe your swallowing problems):

Duration of swallowing problems? Frequency of swallowing difficulty?

Question	YES	NO	Comments
Do you ever have coughing or choking with foods or liquids?			
Do you have problems with foods, liquids and/or both?			
Do you have problems with hot and/or cold foods/liquids?			
Do you have feelings of food getting stuck in your throat?			
Do you have mouth or throat pain?			
Do food and/or liquids ever go up into your nose?			
Do you have problems with gastroesophageal reflux?			
Do you have mouth odor?			
Have you had changes in your taste?			
Do you have dry mouth or saliva consistency changes?			
Have you had any speech or voice changes?			
Has your appetite changed or do you find less enjoyment in eating?			
Have you had any weight loss/gain since having swallowing problems?			
Do you ever have shortness of breath?			
Do you receive supplemental oxygen? If so, how many liters?			
Are you missing any teeth? If so, which ones?			
Do you have dentures and/or partials? Specify upper and/or lower.			

Current Nutritional Status:

Diet texture (circle one): Regular Soft Puree

Liquid Consistency (circle one): Thin Nectar Honey Pudding

Are there any foods that you avoid because of your swallowing problems?

Patient Goals:

Caregiver Goals: