



MUSC EVELYN TRAMMELL INSTITUTE
FOR VOICE AND SWALLOWING DISORDERS

Clinical Evaluation of Swallowing Function
Patient Questionnaire

Date of Study: _____

Medical Record #: _____

(office use only)

Please complete in black ink

Patient Name: _____

Date of Birth: _____ Age: _____ Height: _____

Sex: Male Female

Telephone: Home: () _____ Work: () _____

1. This form is being filled out by (circle one)

Patient Spouse Son Daughter Sister Brother

Other (please specify): _____

2. Referred by: _____

3. Do you feel you have a swallowing problem? Yes No

4. In your own words, please describe your swallowing problems: _____

5. When did your swallowing problem begin? _____

6. Was the onset of your swallowing problem: Gradual Sudden

7. Do you live alone or live with a family member or caregiver

8. Are you responsible for preparing your own food? Yes No

9. Do you have a family history of swallowing problems? Yes No

If yes, please explain: _____

10. Have you experienced weight loss? Yes No

_____pounds in_____weeks/months

11. Have you had a change in your appetite? Yes No

If so, describe:_____

12. Have you changed your diet because of your swallowing problems?

Yes No

If yes, please explain:_____

13. Do you have problems swallowing saliva? Yes No

14. If you have difficulty swallowing any of the following foods or drinks, please check them off below:

- thin liquids (water or soft drinks)
- slightly thickened liquids (apricot juice, Ensure)
- very thick liquids (milk shakes)
- pureed foods (apple sauce, pudding)
- chopped foods (meats, vegetables, fruits)
- soft solid foods (whole meats, vegetables)
- solid foods (salad, popcorn)

15. Do you take any dietary supplements, such as Ensure? Yes No

16. Have you ever been seen by a speech pathologist for your swallowing problem? Yes No

17. Have you ever had a barium swallow test? Yes No

If yes, when and where:_____

18. What other specialist(s) have you seen for your swallowing problem?_____

19. Do you have any problems with speech or voice? Yes No

If yes, please describe:_____



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20. Have you ever had pneumonia? Yes No
If yes, when? _____
21. Do you presently have congestion in your chest? Yes No
22. When was your last chest x-ray? _____
23. Do you currently have a tracheotomy breathing tube? Yes No
24. Have you had a tracheotomy breathing tube in the past? Yes No
25. Which of the following are problems for you?
- | | |
|--|---|
| <input type="checkbox"/> coughing | <input type="checkbox"/> dry mouth and throat |
| <input type="checkbox"/> at rest | <input type="checkbox"/> foods sticking in mouth |
| <input type="checkbox"/> interrupting sleep | <input type="checkbox"/> foods sticking in throat |
| <input type="checkbox"/> during eating | <input type="checkbox"/> foods sticking high in the neck |
| <input type="checkbox"/> during drinking | <input type="checkbox"/> foods sticking low in the neck |
| <input type="checkbox"/> after drinking or eating | <input type="checkbox"/> foods sticking middle of the chest |
| <input type="checkbox"/> frequent throat clearing at rest | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> breathlessness during eating/drinking | <input type="checkbox"/> pain during swallowing |
| <input type="checkbox"/> fatigue during eating/drinking | <input type="checkbox"/> fever |
| <input type="checkbox"/> burning acid taste in throat/mouth | <input type="checkbox"/> fear of eating |
| <input type="checkbox"/> frequent indigestion/heartburn | <input type="checkbox"/> excessive saliva or phlegm |
| <input type="checkbox"/> frequent sore throats | |
26. Do you wear dentures: Yes No
If yes, Full Upper Partial Upper
Full Lower Partial Lower
27. Do you have a feeding tube? Yes No
If yes, type: PEG Tube NG tube Other: _____
28. Have you had a feeding tube in the past? Yes No
29. Do you wear a hearing aid? Yes No If yes, Right Left
30. Do you use any of the following assistive devices? Please check all that apply:
- None
 - Prosthesis (example: artificial limb) _____
 - Cane
 - Crutches
 - Brace
 - Walker
 - Wheelchair
 - Glasses or Contacts

31. Are you diabetic? Yes No

32. Have you ever been seen by a dietitian? Yes No

33. Substance Usage:

Smoke _____ packs per day for _____ years

Quit smoking, when _____

Smokeless tobacco use: Chewing tobacco Snuff

Alcoholic beverages _____ per day. Type _____

Diet pills (name, amount, how long?) _____

Caffeine beverages _____ per day. Type: _____

Other drugs/substance usage: _____

34. Do you have any allergies to medications, foods, or other substances?

None that I know of

Yes:

Item/Substance: _____ Reaction: _____

Item/Substance: _____ Reaction: _____

Item/Substance: _____ Reaction: _____

Item/Substance: _____ Reaction: _____

35. Please list your current medications including herbal:

Medication	Dose	Frequency	Last Dose



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36. Medical History: (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Neck/back pain |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney failure/Dialysis | <input type="checkbox"/> Dizziness/Blackouts |
| <input type="checkbox"/> Defibrillator/AICD | <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Chest pain/Angina | <input type="checkbox"/> Nausea/Vomiting/Diarrhea | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Constipation | <input type="checkbox"/> Migraines/Headaches |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart catheterization | <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Nephropathy |

37. Are you: right handed left handed

38. Have you taken cortisone/prednisone in the past year? Yes No

39. Other medical history: _____

40. Please list any surgeries you have had, and when you had them: _____

41. Please list any surgeries planned for you in the future: _____

42. Do you currently have any of the following:

- Tuberculosis
- HIV Positive
- AIDS
- Exposed to measles/mumps/chicken pox in the last 3 weeks
- Other infectious diseases: _____

43. Have you ever had a blood transfusion?

No

Yes: When? _____ Any reaction? _____

I have donated blood for myself

Someone has donated blood for me

I will accept a blood transfusion in an emergency situation to save my life.

I will not accept a blood transfusion in an emergency situation to save my life.

44. Is there any chance you are currently pregnant?

45. Have you been pregnant in the last 3 months?

46. Do you have any special spiritual or cultural needs that you feel we need to know about (food restrictions, religious restrictions, translation needs, etc.)? Yes No

If yes, what are your special needs? _____

47: What is your goal from the evaluation today? _____

Patient Information Reviewed by _____