Stony Brook Medicine

ADULT HEAD AND NECK CANCER
SPEECH/SWALLOWING HISTORY FORM

Name: _____
Date of Birth: _____

Reason for this evaluation: □ Pre-Treatment Evaluation □ Swallowing □ Communication
Previous Speech/Swallow Evaluation: □ No □ Yes □ Stony Brook □ Other: _____
Diagnosis (date/type) _____
Physician name and location: _____
Surgery: □ No □ Yes □Completed □Planned Date/Type:_____
Radiation therapy: □ No □ Yes Date Completed_____ Date Planned_____
sessions/days _____Complications? □ No □ Yes: _____
Chemotherapy: □ No □ Yes Date Completed_____ Date Planned_____
sessions _____ Complications? □ No □ Yes: _____

Past Medical History

Anxiety/Depression	□YES	□NO	Laryngitis	□YES	□NO
Autism	□YES	□NO	Learning Disability	□YES	□NO
ADD/ADHD	□YES	□NO	Lung Cancer	□YES	□NO
Asthma/COPD	□YES	□NO	Mental Retardation	□YES	□NO
Allergies	□YES	□NO	Pneumonia	□YES	□NO
Brain Cancer	□YES	□NO	Shortness of breath	□YES	□NO
Bronchitis	□YES	□NO	Seizures	□YES	□NO
Cardiac Disease	□YES	□NO	Sleep Apnea	□YES	□NO
Cleft Palate	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Cerebral Palsy	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Diabetes	□YES	□NO	Swallowing Problems	□YES	□NO
Dementia	□YES	□NO	Surgery	□YES	□NO
High Blood Pressure	□YES	□NO	□ Cancer □ Other: _____		
Gastric Reflux	□YES	□NO	Thyroid Cancer	□YES	□NO
Hearing Loss	□YES	□NO	Tracheostomy tube	□YES	□NO
Head/Neurological Injury	□YES	□NO	Thyroid Disease	□YES	□NO
Kidney Disorder	□YES	□NO	Visual Impairment	□YES	□NO
Leukemia	□YES	□NO	Voice Impairment	□YES	□NO
			Ventilator Dependency	□YES	□NO

How do you take Medication? □ With water □ In puree □ Other: _____
List medications or attach list:

Current respiratory status: □ No difficulty □ Oxygen use □ Stoma (open hole in neck)
□ Trach tube (size and date placed) #_____
Dry Mouth:□ NO □ YES, how do you manage it? _____
Mucus/phlegm difficulty? □ NO □ YES, how do you manage it? _____
Please check any of the following specialists seen in past: □ Physical or Occupational Therapist
□ Ear Nose and Throat Specialist □ Eye Specialist □ Neurologist □ Psychiatrist/Psychologist □ Pulmonologist
□ Cardiologist □ Neuropsychologist □ Speech/Language Pathologist □ Audiologist (Hearing Test)

Family and Social History: Please check all that apply
□ Working □ Student □ Unemployed □ Retired □ Live alone □ Tobacco user d/c date: _____
□ Alcohol use ___/day □ Recreational drug use

 Reviewed by SBUH SLP _____
Initials

Name: _____
Date of Birth: _____

Swallowing problem: □ No □ Yes: □ Gradual Onset □ Sudden Onset □ Few wks. □ Few mos. □ 6-12 mos.
□ Over ____ years □ Improved over time □ Gotten worse over time □ Stayed the same over time
If yes, describe any management strategies you are using to swallow: _____
_____

Current diet/nutrition/hydration: Check all that apply □ Feeding tube □ Regular □ Cut up/soft foods
□ Finely chopped □ Puree □ Thin liquids □ Slightly thick liquids □ Nectar thick liquids □ Honey thick liquids
□ Good appetite □ Fair appetite □ Poor appetite □ Recent weight loss - __# of lbs. over ___ weeks/mos.
□ Food allergies: _____ □ Other: _____
_____# meals/feedings per day Length of meal time: _____ minutes □ Assistance with meals

Do you wear dentures? □ No □Yes Circle: Upper / Lower / Partial
Current physical status: □ Walk independently □ Walker □ Cane □ Wheelchair
Please describe your voice: □Normal □ Hoarse □Breathy □Weak □ No voice

Do you experience any of the following? (Check all that apply)

□ Poor morning voice quality	□ Throat soreness or burning sensation not related to illness
□ Frequent throat clearing	□ Coughing episodes not related to illness/swallowing
□ Increased phlegm in the throat	□ Heartburn (If checked, how many times per week? ____)
□ Tastes repeating after meals	□ Feeling of a lump in the throat when swallowing
□ Increased throat/mouth dryness	□ Bad taste in the mouth (sour, acidic, metallic)
□ Frequent burping	□ Unpredictable/variable voice quality during the day
□ Feeling of throat tightness	□ Increased coughing when lying down

Current communication: □ Speech □ Writing □ Electrolarynx
□ Gestures □ Communication/letterboard □ Other: _____

Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

□ **Reviewed by SBUH SLP_____ _____**
Name/ ID number **date/time**

SLP Notes: