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Adult
History and Background Information
Past Medical History

Name: _____
Date: _____
D.O.B.: _____

Describe your problem:

When did you first notice your problem? _____

Can you think of any reason or cause for your problem? _____

Has anyone else in your family had a speech or hearing problem? _____

Describe any serious illnesses, accidents, or surgery you have had. (Give age at occurrence and severity.)

Etiologies	Yes	No	Additional Information
Allergies			
Asthma			
Broken Nose			
Bronchitis			
Chronic Colds			
Chronic Laryngitis			
Clef Palate			
Ear Disease			
Hearing Problem			
Heart Trouble			
Hypertension			
Hypothyroidism			
Incoordination of face or tongue Muscles			
Influenza			
Mouth-Breathing			
Numbness			
Paralysis/ Paresis			
Pneumonia			
Sinus Infection			
Tremor/Twitching			
Visual Problem			

Please list any other previous medical history that you feel is important for us to know

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Adult
History and Background Information
Past Medical History continued

Name:
Date:
D.O.B.:

	Yes	No	How much or How many
Alcohol consumption			
Cigarette Use			

List all surgical procedures (related or unrelated to the voice problem).

Swallowing

Patients description of swallowing problem

How long have you had swalowing problems
When was It first identified
Please describe your current diet

What are the easiest foods to swallow: Solids Pastes Liquids
Other:

When eating do you have difficulty chewing the food
When eating do you have difficulty moving the food from the front to the back of the mouth

After swallowing does some food remain in your mouth
After swallowing does some food remain in your throat
After swallowing does some food feel like you need to cough or choke
Do you cough often
Is it painful to swallow
Do you have reflux
If you have reflux are you taking medication
Have you had any previous swallowing evaluations

What are your expectations of this clinic?

Signature: Date: