Dysphagia Case History

MEDICAL HISTORY

Do you have a diagnosis of reflux, GERD, and/or LPRD? ___________________________

History of aspiration pneumonia: YES NO

Neurological deficits: YES NO

Cardiac problems: YES NO

Respiratory problems: YES NO

Circle all that apply within the text box below.

arthritis	kidney disease	pacemaker
blood sugar	cancer	GI disorders
asthma	headaches	blood thinner
diabetes	bronchitis	

Do you wear dentures? YES NO Circle: Upper / Lower / Partial

What is your current physical status? Walking / Cane / Wheelchair

Can you support your upper body? YES NO

Please describe your voice: Normal Hoarse Breathy Weak No voice

SWALLOWING INFORMATION:

Please describe your swallowing problem: ____

____

Onset of swallowing problems:

Gradual Sudden Past few weeks 6-12 months Over ____ yrs.

How would you rate your swallowing problem:

Mild concern Somewhat concerned Very concerned

Has the problem changed over time: Improved Worsened Same

If you have a feeding tube, please report the following:

Date of placement: ____

Times for intake:____

Type of tube: ____

Amount of feedings per day by ounce: ______________________________

Are you on any current medications: _______________________________ YES

(please describe) ________________________ NO

Do you have dietary restrictions for foods and liquids that you are eating?

____

Please describe the consistency of foods and liquids:

Regular foods Cut up or soft foods Finely chopped Pureed

Thin Liquids Nectar thick liquids Honey thick liquids

Circle the items listed below that you have trouble chewing or swallowing:

Thin Liquids:	Water, apple juice, black coffee
Thick liquids:	Coffee with cream/sugar/milk, orange juice, V8
Soft foods:	Cooked vegetables, mashed potatoes
Chopped meats:	Ground beef, chicken, sausage
Breads:	Sandwich bread, toast, corn bread, rice, biscuits
Crunchy foods:	Raw vegetables, pretzels, dry cereal, chips
Chewy foods:	Granola, cheese, raisins, French fries

Length of meal time: <20 minutes 20-30 minutes >30 minutes

Do some meals take longer to eat than others? Please describe: ____________________

____

Please describe any management strategies you are using to swallow your current diet. __

____

Do you require assistance with meals? YES NO

Symptoms

Have you had a recent weight loss? YES:____lbs. over ___weeks NO

Describe your appetite: Good Fair Poor

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

- Poor morning voice quality
- Pain during swallowing
- Throat soreness or burning
- Frequent throat clearing
- Coughing episodes
- Increased phlegm in the throat
- Heart burn
- Inability to keep food down
- Nose running during meals
- Tastes repeating
- Feeling of a lump in the throat
- Throat/mouth dryness
- Bad taste in mouth (sour, acidic, metallic)
- Feeling of food getting stuck
- Difficulty initiating the swallow
- Frequent burping
- Difficulty taking medications
- Difficulty drinking from a straw
- Unpredictable/ variable voice
- Tightness in throat
- Drooling/escape of foods from mouth
- Increased coughing when laying down

Do you take any medication for reflux? YES NO

Please write down any additional information you feel will help us understand your swallowing problem. ____

____

____

Person completing this form: ____

Relation to the patient: ____

Patient signature: ____

Date of completion: ____