

## Swallowing History

1. Please describe the nature of the swallowing problem(s): \_\_\_\_\_

\_\_\_\_\_

2. When did the problem(s) begin: \_\_\_\_\_

3. Has the problem improved at all since it began?  Y  N

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

4. Does the problem(s) only occur with certain foods or liquids?  Y  N

If yes, please list which foods or liquids: \_\_\_\_\_

\_\_\_\_\_

5. Does the problem(s) present only at certain times of day?  Y  N

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

6. Has the patient had a video swallowing study?  Y  N

If yes, when and where? \_\_\_\_\_

What were the findings? \_\_\_\_\_

\_\_\_\_\_

7. Is the patient willing to sign a release so this clinic can obtain a copy of the study findings?  Y  N

If yes, patient will be provided with the proper form for signature.