

# Voice and Swallow Clinics

## Medical Intake Form for **NEW Swallow** Patients

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Date: \_\_\_\_\_

MRN (Staff Input) \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

› How did you hear about our UW Health Voice and Swallow Clinics?

- |  |   |
|--|---|
| <input type="checkbox"/> Community education | <input type="checkbox"/> Public event             |
| <input type="checkbox"/> Radio               | <input type="checkbox"/> From medical referrals   |
| <input type="checkbox"/> Newspaper           | <input type="checkbox"/> Other, please list _____ |

› You were referred to this clinic by your:

- Primary care doctor
- Otolaryngologist
- Speech pathologist
- Self
- Other \_\_\_\_\_

Name of person who referred you \_\_\_\_\_

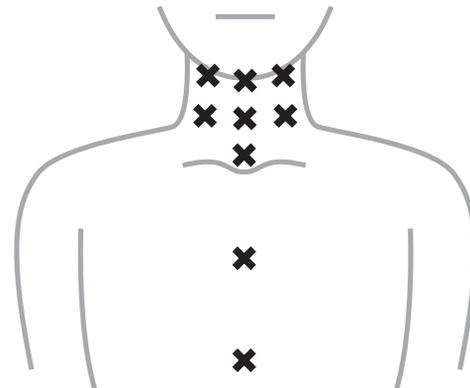
**1. Are you having symptoms of swallowing difficulties?**  Yes  No (if no, please skip to section #3)

**2. Describe the nature of your swallowing function:**

- › When did you first become concerned about your swallowing problem (estimate date)? \_\_\_\_\_
- › Did the problem begin suddenly or gradually?  Suddenly  Gradually  Not sure
- › Is it getting?  Better  About the same  Worse
- › In the past, swallowing has been:  Normal  A little difficult  Somewhat difficult  Very difficult
- › Do you ever feel that food, liquid or pills get stuck?  Yes  No  Occasionally

› Where do you feel food or liquid gets stuck? (circle "x" where food, liquid or pills get stuck)

› If other places, please describe:  
\_\_\_\_\_  
\_\_\_\_\_



- › Do you avoid certain SOLID foods because of difficulties swallowing them?  Yes  No  Occasionally
- › Do you avoid certain LIQUIDS because of difficulties swallowing them?  Yes  No  Occasionally  
If yes to above questions, please describe \_\_\_\_\_
- › Do you have pain upon swallowing?  Yes  No  Occasionally
- › Are there things you have stopped doing because of your swallowing problems?  Yes  No  
If yes, please list \_\_\_\_\_  Occasionally
- › Have you had any choking episodes warranting the Heimlich maneuver?  Yes  No
- › Do you have a history of previous swallow evaluation(s)?  Yes  No

Please list where and when previous studies were performed:

Location \_\_\_\_\_

Date(s) \_\_\_\_\_

- › Do you have:  Own teeth  Full set of dentures  Partial set of dentures  No dentures

**3. Have you experienced any of the following in recent months (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Excessive sweating                                | <input type="checkbox"/> Double vision                       |
| <input type="checkbox"/> Weight gain: ____ lb in weeks/months (circle one) | <input type="checkbox"/> Numbness of the face or extremities |
| <input type="checkbox"/> Weight loss: ____ lb in weeks/months (circle one) | <input type="checkbox"/> Tingling around the mouth or face   |
| <input type="checkbox"/> Palpitation (fluttering) of the heart             | <input type="checkbox"/> Burred vision or blindness          |
| <input type="checkbox"/> Emotional/mood swings                             | <input type="checkbox"/> Weakness or paralysis of the face   |
| <input type="checkbox"/> Clumsiness in arms or legs                        | <input type="checkbox"/> Confusion or loss of consciousness  |
| <input type="checkbox"/> Shaking or tremors in your body movements         | <input type="checkbox"/> Memory Change                       |

**4. Describe your current diet:**

› Solids (choose one that best describes your diet)

- Any solid foods
- Foods are solid but moist; I avoid dry foods or those that are difficult to chew
- Foods must be chopped with gravy or sauce to moisten
- All solids are pureed
- No solids

› Liquids (choose one that best describes your diet)

- Any liquids
- Thicken liquids to nectar consistency
- Thicken liquids to honey consistency
- Pudding thick consistency only
- No liquids

› Nothing or limited intake by mouth:

- Tube feeding and limited oral intake
- Tube feeding and no oral intake
- NA

› Has your swallow problem caused you to eat less?  Yes  No  
If yes, how much less?  25%  50%  75%  100%

**5. Other history**

› Do you smoke cigarettes?

- Never
- Yes, in the past: packs per day \_\_\_\_; Number of years \_\_\_\_; Quit in \_\_\_\_ (month/year)
- Yes, currently: packs per day \_\_\_\_; Number of years \_\_\_\_

› Do you have the following allergies?

- |            |   |                             |
|------------|---|-----------------------------|
| Food       | <input type="checkbox"/> Yes, list: _____ | <input type="checkbox"/> No |
| Medication | <input type="checkbox"/> Yes, list: _____ | <input type="checkbox"/> No |

› Have you had surgery to your larynx?  Yes, number of times : \_\_\_\_  No

Date(s) of surgery(surgeries) \_\_\_\_\_

Your current voice, compared to before surgery, is:  Worse  Better  Same

› Have you ever had radiation therapy to the head, neck or chest?  Yes  No

› Have you had pneumonia in the last 2 years?  Yes  No

**6. Please rate how the following problems have affected you within the past month**

"0" = No problem

"5" = Severe problem

Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or post nasal drip	0	1	2	3	4	5
Difficulty swallowing foods, liquids, or pills	0	1	2	3	4	5
Coughing after you eat or lie down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat, or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5
(For staff input only) <b>RSI score:</b> _____						

**7. To what extent are the following scenarios problematic for you:**

"0" = No problem

"4" = Severe problem

My swallowing problem has caused me to lose weight	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals	0	1	2	3	4
Swallowing liquids takes effort	0	1	2	3	4
Swallowing solids takes extra effort	0	1	2	3	4
Swallowing pills takes extra effort	0	1	2	3	4
Swallowing is painful	0	1	2	3	4
The pleasure of eating is affected by my swallowing	0	1	2	3	4
I cough when I eat	0	1	2	3	4
Swallowing is stressful	0	1	2	3	4
(For staff input only) <b>EAT score:</b> _____					

## SF-12v2® Health Survey Standard Version

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:  Excellent  Very Good  Good  Fair  Poor

2. The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:			
b. Climbing several flights of stairs:			

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like					
b. Were limited in the kind of work or other activities:					

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like:					
b. Did work or activities less carefully than usual					

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?  Not At All  A Little Bit  Moderately  Quite a Bit  Extremely

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?					
b. Did you have a lot of energy?					
c. Have you felt downhearted and depressed?					

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All the time  Most of the time  Some of the time  A little of the time  None of the time

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