Dysphagia Questionnaire

Please complete this form and bring with you on the date of your appointment.

What are your complaints regarding your swallowing? ____________________________

Date of onset of swallowing problems: _________________________________________

Check the problems you are currently experiencing:  (If a choice is provided, circle the appropriate answer.)

- Drooling during non-mealtimes
- Losing food or liquid or both from your mouth during meals
- Difficulty drinking with a straw
- Difficulty chewing
- Difficulty moving food or liquid or both out of the mouth and into the throat
- Difficulty getting the swallow started
- Pain during swallow
- Food or liquid or both coming out of the nose
- Coughing or choking with food or liquid or both
- Frequent throat clearing or coughing or both after the swallow
- Sneezing during meals
- Eyes watering during meals
- Nose running during meals
- Sensation of food sticking in the throat or chest—where specifically? __________________________
- Difficulty swallowing pills
- Needing to avoid certain food or liquid or both
- Regurgitation or being unable to keep food or liquid or both down
- Burping during or after or both meals
- Coughing or choking on saliva during non-mealtimes
- Foreign body sensation in throat
- Sudden coughing after lying down
- Waking at night coughing or choking
- Thickened/excess mucus or secretions
- Ulcers or sores in mouth
- Dry mouth
- Decreased mouth/jaw opening
- Other _______________________________________

Current Diet: □ Nothing by mouth (PEG/N-G tube/TPN) □ Oral intake
              Solids: □ Regular □ Soft □ Pureed
              Liquids: □ Thin or regular □ Nectar-thick □ Honey-thick

How much of your daily intake do you eat by mouth?
ALL MORE THAN HALF HALF LESS THAN HALF NONE

How much of your daily intake goes into a feeding tube?
ALL MORE THAN HALF HALF LESS THAN HALF NONE

Do you frequently use a straw with liquids? Yes No

Do you avoid certain foods because of your swallowing difficulties? Yes No

Explain: _________________________________________________________________


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Does it take you longer to eat a meal than others?  Yes      No

When do you have difficulty at mealtimes?  The beginning/middle/end/throughout the meal.  (Circle one.)

How frequently do you have trouble?  All the time/Sometimes/Occasionally.  (Circle one.)

Have you had previous dysphagia therapy with or without NMES/ e-stim?  Yes      No

Have you had a previous MBS (Modified Barium Swallow study) performed with a Speech-Language Pathologist in a Radiology suite?  Yes        No

Have you had a previous FEES assessment (Fiberoptic Endoscopic Evaluation of Swallowing) with a flexible scope inserted into the nose?  Yes        No

Have you had any recent Chest X-Rays?  Yes        No

Pertinent Medical History:

□ Reflux/GERD/LPRD  Current reflux medication and dosage/frequency: ____________

□ Esophageal disorders:  Explain: ____________________________

□ History of aspiration  □ Pneumonia:  Date: ____________

□ Neurological deficits:  Explain: ____________________________

□ Cardiac problems/disorders:  Explain: ____________________________

□ Pulmonary/Respiratory disorders:  Explain: ____________________________

□ Head and Neck Cancer:  Location/type and date of diagnosis: ____________________________

Do you have an active, untreated lesion in your head or neck? ____________

Surgery and dates: ___________________________________________________________________

Chemotherapy/Radiation (Circle one or both)  Current/Completed (Circle one)

Date of completion: ____________ or # of treatments to date: ____________

□ History of Voice Problems:  Explain: ____________________________

Other Medical History:

□ Arthritis  □ Asthma (adult/childhood onset)  □ Bronchitis
□ Blood Sugar (high/low)  □ Diabetes (adult/childhood onset)  □ Headaches
□ High Blood Pressure  □ Kidney/Bladder Disease  □ Liver Disease
□ Joint/Bone Disease  □ Cancer (other than head and neck)  □ Tuberculosis
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- Depression
- Thyroid disease
- Bleeding Problems
- Endocrine Disorder
- GI Disorders (hernia, ulcers, colitis, etc.)
- Sinus Disease
- Peripheral neuropathy
- Deep Brain Stimulation implants
- Pacemaker
- Internal cardiac defibrillator

Other: ____________________________

Current Medications including over-the-counter: ________________________________

Do you have allergies to foods? drugs? environment? ______________________________

Dentition/Teeth:  
- Natural
- Dentures
- Edentulous/No teeth
- Partial/Bridges
- Missing teeth

Current weight: _____ lbs.  
- Recent Weight Loss: ____ lbs.

Hydration:  
How much of the following do you drink per day? 1 cup/glass = 8 ounces

How many ounces of water do you drink per day? ______

How many ounces of the following caffeinated beverages do you consume per day?  
- Coffee______  
- Tea______  
- Soda______  
- Energy drinks______  
- Chocolate______

How often do you drink alcoholic beverages (daily, weekly, monthly, rarely, never, etc.)? ______

Amount in ounces:  
- Beer______  
- Wine______  
- Liquor______

How many ounces of the following beverages do you drink per day?  
- Milk______  
- Juice______  
- Sports drinks______  
- Other (please specify)______________________________

Are you currently taking antihistamines?_______ If yes, list type and dosage.______________________________

Are you currently using tobacco products?_______ If yes, list type______________________________

How much (packs/cans/etc.) per day?_______ For how long?_______

Have you used tobacco products in the past?_______ If yes, list type______________________________

How much (packs/cans/etc.) per day?_______ For how long?_______ Date of cessation_______

Are you exposed to secondhand smoke? Explain:______________________________

Do you use products containing menthol?_______ If yes, please explain______________________________

Do you take Vitamin C supplements?_______ If yes, please list amount (mg) per day______________________________

Do you use recreational drugs?_______ If yes, please list type/amount/frequency______________________________
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Social History:
Marital Status: □ Married □ Single □ Widowed □ Divorced

Education Level: ____________________ Occupation: ____________________________

Living Arrangements:
□ House □ Apartment
□ Independent Living Facility □ Assisted Living Facility
□ Skilled Nursing Facility

Assistance needed: □ Caregiver □ No caregiver

Goals regarding swallowing: ____________________________

_______________________________________________________________________________

Would you like this report sent to someone other than the referring physician? Please provide name and contact information.
_______________________________________________________________________________

_______________________________________________________________________________

Do you have a follow-up appointment scheduled with your referring physician? If so, please list date and time.
____________________________________________________________________________________