Swallowing Questionnaire to Provide Additional History

Patient ______________________________ SLP ______________________________

Date ______________

1. Do you have any problems with swallowing? ❐ yes ❐ no

   If so, when did the problem start? ______________________________

   ____

   Briefly describe the difficulty. ______________________________

   ____

2. Did the start of your swallowing problem relate to other medical problems you have? ❐ yes ❐ no

   If so, please describe: ______________________________

   ____

3. When you eat or drink, do you have episodes of coughing? ❐ yes ❐ no

   When you eat or drink, do you have episodes of choking? ❐ yes ❐ no

4. Do you wear dentures when you eat? ❐ yes ❐ no

5. Does food or drink ever "go down the wrong way"? ❐ yes ❐ no

6. Does your food generally require special preparation before you can eat it? ❐ yes ❐ no

   If so, please describe: ______________________________

   ____

7. Do you avoid certain foods because they are difficult to swallow? ❐ yes ❐ no

   If so, please list examples: ______________________________

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8. Do you find food in your mouth after you swallow? ❒ yes ❒ no

9. Do you have difficulty keeping food or drink in your mouth? ❒ yes ❒ no

10. Do liquids ever come back through your nose when you swallow them? ❒ yes ❒ no

11. Do you ever feel that food gets "stuck" in your throat? ❒ yes ❒ no

    If so, describe where it feels stuck. ______________________________

12. Do you regularly wake up at night coughing? ❒ yes ❒ no

13. Do you often wake up with a bad/sour taste in your mouth? ❒ yes ❒ no

14. Is your swallowing problem intermittent / constant? (Circle one.)

15. Has your swallowing problem changed over time? ❒ yes ❒ no

    If so, please describe: ______________________________

    ____

16. Are there any factors that make your swallowing problem worse? ❒ yes ❒ no

    If so, please describe: ______________________________

    ____

17. Do you have more difficulty swallowing when in any certain position? ❒ yes ❒ no

    If so, please describe: ______________________________

    ____

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18. Have you had pneumonia recently? ❒ yes ❒ no

    If so, when? ______________________________

    ____

19. Has your voice changed in the past year? ❒ yes ❒ no
    If so, check all that apply:

    ❒ hoarse ❒ quieter
    ❒ whispery/breathy ❒ other ______________

20. Did the changes in your voice start gradually / suddenly? (Circle one.)

21. What was the date of onset of your voice change? ______________

22. Has your speech changed in the past year? ❒ yes ❒ no
    If so, check all that apply:

    ❒ slurring
    ❒ need to clear your throat more
    ❒ talking through your nose
    ❒ other ______________

23. Did the changes in your speech start gradually / suddenly? (Circle one.)

24. What was the date of onset of your speech change? ______________

25. Have you had any previous swallowing or throat problems? ❒ yes ❒ no

    If so, please describe: ______________________________

    ____

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