Stony Brook Medicine

PEDIATRIC SPEECH PATHOLOGY
FEEDING-SWALLOWING HISTORY FORM

Name: ___________________________
Date of Birth: _____________________

Reason for evaluation: ____
Previous Swallow Evaluation: □ No □ Yes □ Stony Brook □ Other: _______________________

Pregnancy/Birth History (check all that apply): □ Full term □ Preterm: __________ weeks gestation
Pregnancy: □ Uncomplicated □ Complicated: □ Tobacco/alcohol/drug use □ Other_____________________
□ Birth Complications: □ Breathing Problems □ Feeding Problems □ NICU

Developmental History:

Sitting/walking:	□ Within Normal Limits	□ Delayed Development
Trained for bowel/bladder:	□ Within Normal Limits	□ Delayed Development
Bottle/breast/spoon feeding:	□ Within Normal Limits	□ Delayed Development
Chewing solids:	□ Within Normal Limits	□ Delayed Development
Control of saliva/drool:	□ Within Normal Limits	□ Delayed Development
Speech production/understanding:	□ Within Normal Limits	□ Delayed Development

Therapy history: □ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Feeding Therapy
□ Early Intervention/Developmental Program □ Preschool/Pre-K □ K-12 □ Special Education Class
Growth: Height/Weight: □ Within Normal Limits □ Delayed Development – if known, percentiles: __________
Pacifier Use: □ Yes □ No

Current diet/nutrition/hydration: Check all that apply □ Feeding tube □ Regular diet □ Cut up/soft foods
□ Finely chopped □ Puree □ Baby food □ Thin liquids □ Slightly thick liquids □ Nectar thick liquids
□ Honey thick liquids Liquids taken by: □ Bottle - type: ___________________________________
□ Sippy cup - type: _______________________ □ Regular cup □ Spoon: ___________________________
□ Good appetite □ Fair appetite □ Poor appetite □ Recent weight loss - __# of lbs. over ___ weeks/mos.
□ Food allergies: ______________________________ □ Other: ____________________________________
_____# meals/feedings per day Length of meal time: _______ minutes □ Assistance with meals

Past Medical History

Anxiety/Depression	□YES	□NO	Kidney Disorder	□YES	□ NO
Autism	□YES	□NO	Learning Disability	□YES	□NO
ADD/ADHD	□YES	□NO	Leukemia	□YES	□NO
Asthma/COPD	□YES	□NO	Intellectual Dev. Delay	□YES	□NO
Allergies	□YES	□NO	Pneumonia	□YES	□NO
Brain Cancer	□YES	□NO	Radiation Therapy	□YES	□NO
Bronchitis	□YES	□NO	Seizures	□YES	□NO
Cardiac Disease	□YES	□NO	Shortness of breath	□YES	□NO
Cleft Palate	□YES	□NO	Sleep Apnea	□YES	□NO
Cerebral Palsy	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Cancer	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Chemotherapy	□YES	□NO	Swallowing Problems	□YES	□NO
Diabetes	□YES	□NO	Surgery:	□YES	□NO
Gastric Reflux	□YES	□NO	______________________________		
Head/Neurological Injury	□YES	□NO	Tracheostomy tube	□YES	□NO
Hearing Loss	□YES	□NO	Visual Impairment	□YES	□NO
Voice Impairment	□YES	□NO	Ventilator Dependency	□YES	□NO

List medications or attach list:

Name: ___________________________
Date of Birth: _____________________

Please check any of the following specialists seen in the past: ☐ Physical or Occupational Therapist
☐ Ear Nose and Throat Specialist ☐ Eye Specialist ☐ Neurologist ☐ Psychiatrist/Psychologist ☐ Pulmonologist
☐ Cardiologist ☐ Neuropsychologist ☐ Speech/Language Pathologist ☐ Audiologist (Hearing Test)

Additional Information:
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Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Reviewed by SBUH SLP______________________________________ ____________________
Name/ ID number **date/time**

SLP Notes: