Stony Brook Medicine

PEDIATRIC SPEECH PATHOLOGY
SPEECH RESONANCE HISTORY FORM

Name: _____
Date of Birth: _____

Reason for evaluation: □ Nasal speech □ Reduced speech intelligibility □ 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

History of Cleft: □ No □ Yes: Lip: □ Left □ Right □ Complete □ Incomplete Date of Repair: _____
Palate: □ Left □ Right □ Hard and Soft Palate □ Soft Palate □ Submucus Date of Repair: _____
□ Pharyngoplasty □ Pharyngeal Flap □ Other Related Surgeries: _____

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
Current Speech Therapy: _____#/week □ Individual □ Group
Current Educational Setting: □ Early Intervention/Dev. Program □ Preschool □ K-12 □ Special Ed. Class
Current Diet: _____ Liquid escapes into nose when drinking: □ Yes □ No
Bottle/Pacifier Use: □ No □ Yes - discontinued (date): _____

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	Tongue tie	□YES	□NO
Voice Impairment	□YES	□NO	Ventilator Dependency	□YES	□NO
Visual Impairment	□YES	□NO			

List medications or attach list:

 Reviewed by SBUH SLP _____

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:
_____
_____
_____

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: