

Craig H. Zalvan, MD, FACS
The Institute for Voice and Swallowing Disorders
Swallow Intake Form

Please fill out this form in black ink as completely as possible and bring to your scheduled Appointment.

IDENTIFYING INFORMATION

Name: _____ Date: _____
Age: _____ Profession: _____

HISTORY OF PRESENT SWALLOWING/THROAT COMPLAINT:

1. Describe your problem:

- a. Current Diet:
- b. Current Feeding Status (Oral, Feeding Tube):
- c. Do you have trouble swallowing certain foods ? Solids Liquids Both Neither
 - i. Describe:
- d. Do you cough if you eat/drink ? Solids Liquids Both Neither
- e. Have you had pneumonia in the past ? When ?

2. Estimate the severity of the problem:

1 – not at all 2 – mild 3 – Moderate 4 - Severe

3. When did you first notice the throat/swallow problem?

4. Onset of problem: Sudden Gradual

5. On a scale of 0 (none) to 10 (severe), what is your level of pain associated with your swallowing/throat problem ? _____

6. Were any events associated with the onset of your problem ? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Swallowed an object | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Medical Illness (stroke, diabetes, etc...) | <input type="checkbox"/> Injury (trauma) |
| <input type="checkbox"/> Upper respiratory infection (cold/flu) | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (specify): | |

7. What do you think is the cause of your throat/swallow problem:

8. Is the problem getting: Better Worse Same Fluctuates

9. Swallowing during the day: Better morning afternoon evening
 Worse morning afternoon evening

10. Please check all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Frequent throat clearing |
| <input type="checkbox"/> Fatigue (voice tires easily) | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Voice too loud | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Voice too soft/weak | <input type="checkbox"/> Dry mouth or throat |
| <input type="checkbox"/> Pitch too high | <input type="checkbox"/> Sensation of phlegm in throat |
| <input type="checkbox"/> Pitch too low | <input type="checkbox"/> Tickling or choking sensation |
| <input type="checkbox"/> Frequent voice breaks | <input type="checkbox"/> Tightness or tension in throat |
| <input type="checkbox"/> Breathiness | <input type="checkbox"/> Something stuck/Lump in throat |
| <input type="checkbox"/> Raspiness | <input type="checkbox"/> Hard and abusive laughter |
| <input type="checkbox"/> Frequent yelling or loud talking | <input type="checkbox"/> Frequent thirst/dehydration |
| <input type="checkbox"/> Frequent whispering | <input type="checkbox"/> Pain in throat while talking |
| <input type="checkbox"/> Hard or Frequent coughing | <input type="checkbox"/> Bad/acid taste/breath |
| <input type="checkbox"/> Losing your voice completely | <input type="checkbox"/> Frequent sore throat |
| <input type="checkbox"/> Straining or effort in speaking | <input type="checkbox"/> Post-Nasal drip |
| <input type="checkbox"/> Loss of range ? <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Run out of air when speak/sing | <input type="checkbox"/> Coughing with food/drink |
| <input type="checkbox"/> Tremulous voice | <input type="checkbox"/> Lecturing |
| <input type="checkbox"/> Noisy breathing | <input type="checkbox"/> Yelling (sports event, house, kids) |
| <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Aggressive personality |
| <input type="checkbox"/> Calling kids/pets from a distance | <input type="checkbox"/> Exposure to dust, fumes, chemicals |
| <input type="checkbox"/> Nasal voice | <input type="checkbox"/> Loud or strenuous singing |
| <input type="checkbox"/> Cheerleading or pep club | <input type="checkbox"/> Imitating Voices/Sounds |
| <input type="checkbox"/> Seasonal Problem | <input type="checkbox"/> Frequent exercise (grunting, lifting, aerobics) |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Choking episodes |
| <input type="checkbox"/> Other (explain) | <input type="checkbox"/> None |

11. Situations that: Worsen the throat:
 Improve the throat:

12. Previous swallow problems ? No Yes, describe:

13. Previous swallow therapy ? No Yes, describe (who, where, how long)
13. What treatments have you received for your throat/swallow problem ? Home remedies ?
14. Have you had any prior diagnostic tests ? If yes, what were the results ?
15. How would you rate your level of stress: Low Average High

Medical History

Do you have or have you had any problems listed below? Please check all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Neck/Back pain |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Kidney disease/Stones | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney failure/Dialysis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Defibrillator/AICD | <input type="checkbox"/> Crohn's/Colitis/IBD | <input type="checkbox"/> Black out/Dizziness |
| <input type="checkbox"/> Chest pain/Angina | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Parkinsons/Alzheimers |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Irregular heart beat/EP study | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> ALS (Lou Gehrig's Disease) |
| <input type="checkbox"/> Previous heart catheterization | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Poor circulation in legs | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Migraines/Headaches |
| <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Sickle cell disease | |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Endocrine disorder | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Immunologic Disease | | |
| <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Cortisone/Prednisone last 12 mo. | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cleft palate |
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Nephropathy |
| <input type="checkbox"/> Sinus problems/post nasal drip | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Head injury | <input type="checkbox"/> Tubes, lines or drains |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Hearing aid(s) | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Neurologic problems (weakness, numbness, clumsiness, tremors/shaking, confusion) | | |
| <input type="checkbox"/> Assistive devices (prosthesis, cane, crutches, brace, walker, wheelchair) | | |
| <input type="checkbox"/> Pregnant now or within the last three months | | |
| <input type="checkbox"/> Other (specify): | | |

Details of any problem checked above:

Surgical History (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Oral surgery | <input type="checkbox"/> Thyroid surgery |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Tracheotomy | <input type="checkbox"/> Radiation (Specify): |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Back/Neck surgery |
| <input type="checkbox"/> Abdominal surgery | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Larynx/Vocal Fold surgery | | |
| <input type="checkbox"/> NONE | <input type="checkbox"/> Other (specify): | |

Details of any surgeries checked above:

Allergies (Medications, food, iodine, latex, tape, novacaine, shellfish, environment)

- None Known
- Allergic to:

Social History:

Substance Usage, Diet (check all that apply):

- Smoke _____ packs per day for _____ years
 - Quit smoking; date: _____
- Alcoholic beverages _____ per day, _____ per week; Type: _____
- Diet pills: Name: _____, Amount: _____, How long: _____
- Caffeine beverages: _____ per day. Type: Cola Coffee Tea
- Water Intake: _____ glasses/ounces per day
- Other drugs/substance usage: _____
- Any Chemical/Environmental exposure: _____
- Special Diet: _____

Family History (similar problems):

Medication History

Name of Patient: _____ DOB: _____

Initial

Name of Person Completing Form: _____ Date: _____

Please write all medications taken currently or within the last 6 months that have been discontinued. List all prescriptions, over-the-counter medications, vitamins, supplements, herbal remedies. Use the following notations next to each entry:

√ = CURRENTLY TAKING D/C = DISCONTINUED

| MEDICATION Dose/Frequency | Initial Date | | | | | | | | | | | COMMENT |
|------------------------------|-----------------|--|--|--|--|--|--|--|--|--|--|---------|
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|----------|-----------------------|----------|-----------------------|
| INITIALS | PRINTED, LEGIBLE NAME | INITIALS | PRINTED, LEGIBLE NAME |
| | | | |

Review of Systems: (Specify Side or Location if Applicable)

- | | | |
|---|--|--|
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Nasal obstruction |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Itchy nose/face |
| <input type="checkbox"/> Trouble chewing | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Painful swallow |
| <input type="checkbox"/> Regurgitation | | |
| <input type="checkbox"/> Change in skin/hair | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Easily chilled | <input type="checkbox"/> Hypersensitivity to temperature | <input type="checkbox"/> Easy fatigue |
| <input type="checkbox"/> Excessive sweat | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fever | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Jaw pain/tension | <input type="checkbox"/> Neck pain/tension | <input type="checkbox"/> Shoulder pain/tension |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Pain with breathing | |
| <input type="checkbox"/> Shaking/tremor | <input type="checkbox"/> Falling | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Memory change | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Aphasia | <input type="checkbox"/> Stuttering | <input type="checkbox"/> Articulation Disorder |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heartburn/Indigestion/Reflux | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Nausea/Vomit/Diarrhea |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Change in Urination |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Allergies | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Rash | | |

Height: _____ Weight: _____

Details of those items checked above:

Please list any additional information that may be helpful in the diagnosis and treatment of your problem:

TABLE 1

Reflux Symptom Index (RSI)

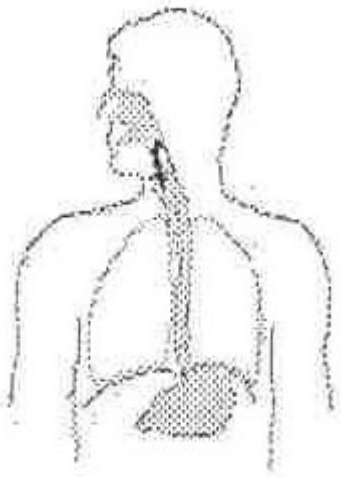
| Within the last MONTH how did the following problems affect you? | 0 = No Problem 5 = Severe Problem | | | | | |
|---|--------------------------------------|---|---|---|---|---|
| 1. Hoarseness or a problem with your voice | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Clearing your throat | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Excess throat mucous or postnasal drip | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Difficulty swallowing food, liquids, or pills | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Coughing after you ate or after lying down | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Breathing difficulties or choking episodes | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. Troublesome or annoying cough | 0 | 1 | 2 | 3 | 4 | 5 |
| 8. Sensations of something sticking in your throat or a lump in your throat | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. Heartburn, chest pain, indigestion, or stomach acid coming up | 0 | 1 | 2 | 3 | 4 | 5 |

Voice Handicap Index (VHI-10), Henry Ford Hospital

Please circle the response that indicated how frequently you have these experiences:

0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

| | | | | | |
|---|---|---|---|---|---|
| My voice makes it difficult for people to hear me | 0 | 1 | 2 | 3 | 4 |
| People have difficulty understanding me in a noisy room. | 0 | 1 | 2 | 3 | 4 |
| My voice difficulties restrict my personal and social life. | 0 | 1 | 2 | 3 | 4 |
| I feel left out of conversations because of my voice. | 0 | 1 | 2 | 3 | 4 |
| My voice problem causes me to lose income. | 0 | 1 | 2 | 3 | 4 |
| I feel as though I have to strain to produce voice. | 0 | 1 | 2 | 3 | 4 |
| The clarity of my voice is unpredictable. | 0 | 1 | 2 | 3 | 4 |
| My voice problem upsets me. | 0 | 1 | 2 | 3 | 4 |
| My voice makes me feel handicapped. | 0 | 1 | 2 | 3 | 4 |
| People ask "What's wrong with your voice?" | 0 | 1 | 2 | 3 | 4 |



Scripps Voice/Swallowing Center
Voice Disorder Assessment

The Glottal Closure Index (GCI) is a four-question survey that assesses the clinical severity of voice disorders. The survey instrument is designed to be used by a physician or vocal specialist in conjunction with other pertinent patient history and physical examination findings. An abnormal GCI (> 2) may be indicative of a significant voice disorder. Please feel free to take and score your GCI below.

The Glottal Closure Index

A score > may indicate a significant voice disorder

| Within the last month, how did the following problems affect you? | 0 = no problem 5 = severe problem | | | | | |
|---|--------------------------------------|---|---|---|---|---|
| 1. Speaking took extra effort | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Throat discomfort or pain after using your voice | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Vocal fatigue | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Voice cracked or sound different | 0 | 1 | 2 | 3 | 4 | 5 |
| Total | | | | | | |