fort worth ent
EAR NOSE & THROAT

Dysphagia Questionnaire

Name: _____ Referring Doctor:_____
Date of Birth: _____ Diagnosis: _____
Address: _____ Phone number: _____
_____ Email: _____

What are your complaints regarding your swallowing: _____
_____
Date and onset of swallowing problems: _____

Please check **all** the following problems that 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 mealtimes
- ☐ 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: _____

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:_____

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 meal. (Circle one.)

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

Pertinent Medical History:

☐ Reflux/GERD/LPR 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: _____

General Medical Health:

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

Other:_____
_____
_____

Current Medications including over-the-counter: _____
_____

Do you have allergies to foods? Drugs? Environmental? _____
_____

Dentition/Teeth: ☐ Natural ☐ Dentures ☐ Edentulous/No teeth
☐ Partial ☐ Missing teeth

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

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

Current weight: _____lbs. Recent Weight Loss: _____ lbs.

Your goals regarding swallowing: _____

_____

Have you had any recent Chest X-Rays: Yes No
Date: _____ Results: _____

Have you had any previous dysphagia therapy with or without NMES/e-stim: Yes No
Date: _____ Location: _____

Have you had a previous MBS (Modified Barium Swallow Study) performed with a Speech-Language Pathologist in a Radiology suite?: Yes No
Date: _____ Results: _____

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

Hydration:
How much of the following you drink per day. *1 cup/glass = 8 oz.*

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

How many ounces of the following caffeinated bevereges do you consume per day?
Coffee_____ Tea_____ Soda_____ Energy Drinks_____ Chocolate_____

How often do you drink alcoholic beverages (daily, weekly, 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, type and dosage: _____

Do you take Vitamin C supplements? YES/NO If yes, please list amount (mg) per day. _____

Are you currently using tobacco products? YES/NO If yes, what type_____
How much (packs/cans/etc.) per day? _____ For how long?_____

Have you used tobacco products in the past? YES/NO If yes, what type_____
How much (packs/cans/etc.) per day? _____ For how long?_____ Date of cessation_____

Are you exposed to secondhand smoke? YES/NO If yes, please explain._____

Do you use products containing menthol? YES/NO If yes, please list._____

Do you use recreational drugs? YES/NO If yes, please list type, amount, and frequency. _____
_____

Would you like this report sent to anyone other than the referring physician? If so, please list name and contact information.

_____

_____

Do you have a follow-up appointment scheduled with your referring physician? If so, please list the date and time so we can send your evaluation results by your next appointment.

_____

_____ _____

Patient Signature Date

REFLUX SYMPTOM INDEX (RSI)

PLEASE RATE HOW THE FOLLOWING PROBLEMS HAVE AFFECTED YOU WITHIN THE LAST MONTH, USING A ZERO-TO-FIVE SCALE, WHERE:

***0= NO PROBLEM** AND **5=SEVERE PROBLEM**.*

1. Hoarseness or a problem with you 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

TOTAL:_____

Belafsky PC, Postma GN, Koufman JA. Validity and reliability of the reflux symptom index (RSI). J Voice. 2002 Jun;16(2):274-7.

M.D. ANDERSON DYSPHAGIA INVENTORY

Name: _____ Date: ___/___/_____

This questionnaire asks for your views about your swallowing ability. This information will help us understand how you feel about swallowing. The following statements have been made by people who have problems with their swallowing. Some of the statements may apply to you.

Please read each statement and circle which response best reflects your experience in the past week.

P My swallowing ability limits my day-to-day activities.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

E I am embarrassed by my eating habits.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

F People have difficulty cooking for me.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P Swallowing is more difficult at the end of the day.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

*E I do not feel self-conscious when I eat.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

E I am upset by my swallowing problem.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P Swallowing takes great effort.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

E I do not go out because of my swallowing problem.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

F My swallowing difficulty has caused me to lose income.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P It takes me longer to eat because of my swallowing problem.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P People ask me, “Why can’t you eat that?”
Strongly Agree Agree No Opinion Disagree Strongly Disagree

E Other people are irritated by my eating problem.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P I cough when I try to drink liquids.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

F My swallowing problems limit my social and personal life.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

*F I feel free to go out to eat with my friends, neighbors and relatives.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P I limit my food intake because of my swallowing difficulty.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P I cannot maintain my weight because of my swallowing problem.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

E I have low self-esteem because of my swallowing problem.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

P I feel that I am swallowing a huge amount of food.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

F I feel excluded because of my eating habits.
Strongly Agree Agree No Opinion Disagree Strongly Disagree

What is your perception of the severity of your swallowing problem?

1	2	3	4	5	6	7

Least severe Most severe

Totals: (to be filled out by SLP)

Consent to Perform Videostroboscopy/FEES

Client Name: _____

I hereby consent to and authorize the performance of videostroboscopy and/or Fiberoptic Endoscopic Evaluation of Swallow (FEES) for assessment of vocal fold structure and functioning to be performed at Fort Worth ENT.

Initial: _____

I consent to the administration of topical anesthetic, if required. I have no known allergies and/or medical conditions that prohibit the use of topical anesthetics.

Initial: _____

The nature and purpose of the procedures and the potential risks involved have been explained to me. Potential risks include allergic reaction to topical anesthetic, bleeding (transnasal endoscopy only), and/or temporary discomfort. No guarantee or assurance has been given by anyone as to the results that may be obtained.

Initial: _____

I understand that all information pertaining to services at Fort Worth ENT is kept confidential and will be made available to other professional personnel only after I have signed an Authorization to Send/Release Information form.

Initial: _____

Fort Worth ENT may participate in research and social media projects to expand knowledge of clinical outcomes in the treatment and evaluation of voice and voice disorders. Further, I understand that audio and/or videotapes of sessions and other case information may be used in these research projects. If I choose not to have my information included in research and social media projects, I do not have to initial here.

Initial: _____

_____ _____

Signature of Client/Parent or Guardian *Date Signed*