UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Modified Barium Swallowing Study
CASE HISTORY FORM

Name:_____ DOB: _____AGE:_____

Primary Doctor:_____Referring Doctor (If different): _____

MEDICAL HISTORY (Check if Applicable)

- ☐ Cardiac Bypass Surgery
- ☐ Anterior Cervical Fusion
- ☐ Dementia
- ☐ Arthritis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer (state type)
- ☐ Stroke
- ☐ Feeding Tube
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Asthma or COPD
- ☐ Multiple Pneumonias
- ☐ Dehydration/Malnutrition
- ☐ ALS
- ☐ Thyroid Disease/Surgery
- ☐ Esophageal Stretching
- ☐ Change in Voice or Speech
- ☐ Chronic Dry Mouth
- ☐ Previous Swallowing Exam or Therapy
- ☐ Head Injury
- ☐ Intubation / # of Days
- ☐ Anxiety

If any Radiation Treatment, to what part of the body?_____

Describe your swallowing difficulty (be as detailed as possible):

_____

_____

_____

_____

How long has this been going on?_____

How do you take your pills?_____

Any trouble swallowing pills? ☐ YES ☐ NO

Which do you have the most difficulty? ☐ Solids ☐ Liquids ☐ Both Solids and Liquids

About how long does it take you to eat a meal?_____

Any trouble with chewing food?_____

How is your appetite? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been losing weight? ☐ YES ☐ NO Gaining Weight? ☐ YES ☐ NO

If so, how much? _____

What texture of foods/liquids do you eat now? ☐ Regular ☐ Soft ☐ Blenderized/Puree

Do you use supplements, such as Ensure or Glucerna? ☐ YES ☐ NO

Describe your teeth: Natural/What condition?_____

Dentures: ☐ Full Upper ☐ Full Lower ☐ Partial Upper ☐ Partial Lower

Do they fit well? ☐ YES ☐ NO

Current Medication list: (Feel free to attached a list)

NAME	REASON FOR MEDICATION	FREQUENCY

Do you have any of the following? If so please check all that apply:

- ☐ Interrupted Sleep
- ☐ Painful Swallowing
- ☐ Lightheaded or Faint
- ☐ Regurgitation of Undigested Food
- ☐ Jaw Pain
- ☐ Gastroesophageal Reflux (GERD)
- ☐ Repeated Swallowing
- ☐ Bloating
- ☐ Acidic, Metallic or Sour taste in back of throat or mouth
- ☐ Neck Pain
- ☐ Hiatal Hernia
- ☐ Belching or Hiccuping
- ☐ Choking Sensation
- ☐ Chronic Cough
- ☐ Ear Pain
- ☐ Dry or Sore Throat
- ☐ Increased Salivation
- ☐ Vomiting
- ☐ Spasms of the Throat or Voice Box
- ☐ Pain inside mouth
- ☐ Bad Breath
- ☐ Chronic Asthma
- ☐ Loss of Voice
- ☐ Aspiration (the entry of foreign material or secretions into the airway)

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 post nasal drip	0	1	2	3	4	5
4. Coughing after you ate or lying down	0	1	2	3	4	5
5. Breathing difficulties or choking episodes	0	1	2	3	4	5
6. Sensation of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
7. Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Anything else in your background, or why you were referred that you think we should know to better evaluate you?

_____

_____

Thank You!

Questions? Please call:
University of Maryland Upper Chesapeake Medical Center: 443-643-3257
University of Maryland Harford Memorial Hospital: 443-843-5331