

Greenville ENT: Pre-Laryngectomy History Form

Name:

DOB:

Today's Date:

Briefly describe your diagnosis (location and type of Cancer or tumor, etc.) and plan for treatment (Chemotherapy, Radiation, Surgery, TEP, etc.):

Briefly describe your symptoms (voice, throat, and swallowing). When did they begin?

Have you ever had a swallowing evaluation, FEES, or Modified Barium Swallow Study (MBS)? YES NO

If yes, when/where: _____

Have you ever had a voice evaluation or a videostroboscopy ("strobe") examination? YES NO

If yes, when/where: _____

Have you had any of the following?

____ Surgery on your larynx (voice box)

____ Pneumonia

____ Heart Surgery

____ Chemotherapy

____ Chest Surgery

____ Stroke

____ Thyroid Surgery

____ Injury to the neck

____ Chemical or Inhalation Exposure

____ Radiation to the head, neck, or throat

Which of the following voice/throat symptoms apply to you?

- Hoarseness
- Breathiness
- Dry throat or mouth
- Lump in the throat feeling
- Constant throat clearing
- Excessive coughing
- Tightness in the nose and/or throat
- Fullness in the nose and/or throat
- Volume disturbance
- Loss of range
- Tickling or choking sensation
- Pain during speaking and/or singing
- Can't yell
- Poor endurance
- Can't be heard in noise
- Varies a lot
- Phone a problem

How does your voice problem affect your life?

Did it begin _____ suddenly or _____ slowly?

Is the problem getting _____ worse, _____ better, or _____ staying the same?

Who first noticed the problem? _____

How many glasses of water do you drink daily? _____ Carbonated drinks? _____

How many cups of caffeine do you have daily (tea, coffee, soda, etc)? _____

How often do you drink alcohol? ____ Never ____ Rarely ____ Weekly ____ A few times a week ____ Daily

Are you involved in any hobbies or activities where you are in contact with dust, fumes, chemicals, or paints? _____

Which of the following swallowing symptoms apply to you?

- ___ Coughing with food
- ___ Coughing with liquid
- ___ Choking with food
- ___ Choking with liquid
- ___ Difficulty swallowing pills
- ___ Food getting stuck in throat
- ___ Mouth Pain
- ___ Throat Pain
- ___ Reflux
- ___ Dry Mouth
- ___ Voice Changes
- ___ Appetite Changes
- ___ Weight Loss
- ___ Weight Gain
- ___ Shortness of Breath
- ___ Supplemental Oxygen if yes, how much? _____
- ___ Missing Teeth If yes, do you wear dentures or partials? _____

What is your current diet?

Thin Liquids	Nectar-thick Liquids	Honey-thick Liquids	
Regular Solids	Mechanical Soft	Pureed	NPO

With which food/liquid consistencies do you have the most difficulty?

- ___ Thin liquids
- ___ Honey-thick liquids
- ___ Mixed Consistency
- ___ Solids
- ___ Other: _____
- ___ Nectar-thick liquids
- ___ Pudding-thick liquids
- ___ Soft Solid
- ___ Pills

Are you ____ Right or ____ Left handed?

Writing Sample (please write 3-5 sentences about yourself):

Which methods of communication do you currently use?

____ Writing

____ Speaking

____ Gestures

____ Sign Language

____ Other: _____

Are you a Veteran? ____ Yes ____ No

Do you have internet at home? ____ Yes ____ No

Do you have a smartphone? ____ Yes ____ No

Do you have a landline telephone? ____ Yes ____ No