Dysphagia Questionnaire

□ Depression
□ Endocrine Disorder
□ Peripheral neuropathy
□ Internal cardiac defibrillator
□ Thyroid disease
□ GI Disorders (hernia, ulcers, colitis, etc.)
□ Deep Brain Stimulation implants
□ Bleeding Problems
□ Sinus Disease
□ Pacemaker

Other:_____

Current Medications including over-the-counter: _____

_____

Do you have allergies to foods? drugs? environmental?_____

_____

Dentition/Teeth: □ Natural □ Partial/Bridges □ Dentures □ Missing teeth □ Edentulous/No teeth

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

Hydration:
How much of the following do you drink per day? 1 cup/glass = 8 ounces

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

How many ounces of the following caffeinated beverages do you consume per day?
Coffee_____ Tea_____ Soda_____ Energy drinks _____ Chocolate_____

How often do you drink alcoholic beverages (daily, weekly, monthly, 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, list type and dosage._____

Are you currently using tobacco products? _____ If yes, list type _____
How much (packs/cans/etc.) per day?_____ For how long? _____

Have you used tobacco products in the past?_____ If yes, list type_____
How much (packs/cans/etc.) per day?_____ For how long?_____ Date of cessation_____

Are you exposed to secondhand smoke? Explain:_____

Do you use products containing menthol?_____ If yes, please explain_____

Do you take Vitamin C supplements?_____ If yes, please list amount (mg) per day_____

Do you use recreational drugs?_____ If yes, please list type/amount/frequency_____