MASSACHUSETTS GENERAL HOSPITAL

SPEECH, LANGUAGE & SWALLOWING DISORDERS AND READING DISABILITIES

Patient's Name:

Guardian's Name:

Date of Birth:

MGH #:

Birth History:

Full Term	☐ YES ☐ NO	If no, how many weeks was your pregnancy:
Complications	☐ YES ☐ NO	If yes, please explain:
Neonatal ICU Stay	☐ YES ☐ NO	If yes, how long was the ICU stay?
Adopted	☐ YES ☐ NO	If yes, age at adoption:

Feeding/Swallowing History:

My child has difficulty swallowing:

- Liquids: ☐ Yes ☐ No
- Solids: ☐ Yes ☐ No

Please briefly describe your child's swallowing problems and your concerns: ______________________

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Has your child ever had a videofluoroscopic swallow study/ VFSS before (also called a "modified barium swallow study" or "MBS") at a facility **other than MassGeneral Hospital *for* Children**?

☐ Yes ☐ No

- If yes, about when? ____
- Where? ____

Has your child ever received feeding therapy or specialist support for eating or drinking: ☐ Yes ☐ No

- If yes, where?

☐ Early Intervention: ________________ ☐ School: ______________________

☐ Hospital-outpatient: ________________ ☐ Private Practice: __________________

☐ Hospital-inpatient (e.g. while in the hospital): ______________________________

How is your child being currently fed? (Check all that apply):

☐ Mouth ☐ G-Tube ☐ J-Tube ☐ NG-Tube

Does your child currently breastfeed? ☐ Yes ☐ No

Does your child currently drink from a bottle? ☐ Yes ☐ No

- If yes, what brand of bottle do they use most often?

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- If yes, what level nipple or flow rate do they use most often?

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Brief Medical History:

Condition	Check if "Yes"	Description
Airway disorder such as laryngomalacia, tracheomalacia, laryngeal cleft, subglottic stenosis, etc.		
Genetic disorder such as Down Syndrome, DiGeorge Syndrome, etc.		
Seizure disorder or epilepsy		
Gastrointestinal disorder such as Eosinophilic Esophagitis, Gastroesophageal Reflux Disease (GERD), Short Bowel Syndrome, etc.		
History of failure-to-thrive or growth problems		
History of stroke		
History of cancer		
Other:		

Has your child every had surgery? ☐ Yes ☐ No

- If yes, please list surgery type and approximate date(s): ______________________________

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Does your child currently take any medications, including nebulizers or inhalers? ☐ Yes ☐ No

- If yes, please list: ____

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Does your child have any food allergies? ☐ Yes ☐ No

- If yes, please list: ____

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