Hackensack
Meridian *Health*
Mountainside
Medical Center

SPEECH-LANGUAGE PATHOLOGY MEDICAL HISTORY FORM

Date of Evaluation:	
Client's Name:	
Date of Birth:	
Sex:	☐ **Male** ☐ **Female**
Information Given By:	
Address:	
Phone Numbers:	**Home:** **Cell:**
	Work: **Other:**
Referring MD:	
Primary Care MD:	
Reason for Referral:	

Date Problem was first noticed:_____

Please list all prior hospitalization and/or surgeries:_____
_____
_____
_____

If you have any of the following, please indicate below:

☐ **High Blood Pressure**	☐ **Osteoarthritis**
☐ **Heart Disease**	☐ **Fibromyalgia Symdome (FMS)**
☐ **Heart Attack: Date:**	☐ **Depression**
☐ **Pacemaker**	☐ **Kidney Disease**
☐ **Stroke/TIA: Date:**	☐ **Alcoholism/Illicit Drug Use**
☐ **Concussion/Head Injury Date:**	☐ **HIV Disease/AIDS**
☐ **Respiratory Problems**	☐ **Developmental Disabilities**
☐ **Asthma**	☐ **Latex Allergy**
☐ **Emphysema**	☐ **Voice Disorder**
☐ **Cancer: What type?:**	☐ **Diabetes Type:**
☐ **Parkinson's Disease**	☐ **Seizures**
☐ **Alzheimer's Disease**	☐ **Multiple Sclerosis**
☐ **Thyroid Disease**	☐ **Hepatitis**
☐ **Reflux/GERD/LPR**	☐ **Anemia**
☐ **Allergies: Please List:**	☐ **Other:**

Please list all medications you are currently taking and dosage (include over the counter):

1.	**11.**
2.	**12.**
3.	**13.**
4.	**14.**
5.	**15.**
6.	**16.**
7.	**17.**
8.	**18.**
9.	**19.**
10.	**20.**

Do you have difficulty swallowing?: ☐ Yes ☐ No
If yes please explain:_____
_____
_____

If yes, are there any specific foods and/or beverages you have difficulty with? (thin liquids, crackers, etc):_____
_____
_____

What is your goal for this evaluation/therapy?: _____
_____
_____

Pain Assessment
Are you currently in pain? ☐ Yes ☐ No
On a scale from 0 to 10, please rate your pain (10 is most severe pain):_____
If yes, where is your pain located?_____
Will your pain interfere with completing this assessment today? ☐ Yes ☐ No
☐ *Recommend follow-up with physician*

Advanced Directives
Do you have an advanced directive? ☐ Yes ☐ No
If no, are you interested in information about an Advanced Directive? ☐ Yes ☐ No
☐ *Information given*

Fall Risk Assessment
Do you have a history of falls? ☐ Yes ☐ No
If yes, when did you last fall? _____

Please make a check if you have any of the following conditions:
☐ Problems with your vision ☐ Parkinson's Disease ☐ Diabetes Mellitus
☐ Confusion ☐ Alzheimer's Disease ☐ Stroke
☐ Sudden and Urgent need to urinate
Please make a check if you take any of the following medications:
☐ Blood Pressure Medication ☐ Laxatives ☐ Pain Relievers ☐ Sleeping Pills

☐ Tranquilizers
☐ *Fall Prevention Guide Given*

Social Assessment

Do you feel safe in your home environment? ☐ Yes ☐ No
Are you being hurt or threatened by anyone? ☐ Yes ☐ No
Other: _____
_____
☐ *Referral to Social Services*

Reviewed assessment with patient and/or family; appropriate referrals made as above.
Patient's Signature:_____ Date:_____
Clinician's Signature:_____ Date:_____