Stony Brook Medicine

Adult Speech-Language Pathology Case History

Name: _____ Date of birth: _____
Telephone: (home) _____(work) _____(cell)_ _____
Reason for evaluation:_____
Insurance: _____ Policy Number: _____Referral Needed: □yes □no
Referred by _____
Person completing form □ Patient □ Spouse □ Parent/Guardian □ Other- Name_____
Results will be sent to names/locations listed below if address or faxes are provided

Name	Address or Fax	Phone

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

Name	Relationship to patient	Address	phone	fax
Name	Relationship to patient	Address	phone	fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.
Signature of □ Patient □ Parent/Guardian _____ Date _____
Printed Name of Parent/Guardian _____

Past Medical History

ADD/ADHD	□YES	□NO	HIV Positive	□YES	□NO
AIDS	□YES	□NO	Hormonal Changes	□YES	□NO
Allergies	□YES	□NO	Laryngitis	□YES	□ NO
Asthma	□YES	□NO	Learning Disability	□YES	□NO
Back Pain	□YES	□NO	Mental Retardation	□YES	□NO
Cancer	□YES	□NO	Physical Limitations	□YES	□NO
Cerebral Palsy	□YES	□NO	Pneumonia/Bronchitis	□YES	□NO
Dementia	□YES	□NO	Respiratory Disease	□YES	□NO
Diabetes	□YES	□NO	Shortness of breath	□YES	□NO
Ear Infections	□YES	□NO	Seizures	□YES	□NO
Epilepsy	□YES	□NO	Sinus Problems	□YES	□NO
Gastric Reflux	□YES	□NO	Speech/Lang Impairment	□YES	□NO
Head Injury	□YES	□NO	Stroke (CVA/TIA)	□YES	□NO
Hearing Loss	□YES	□NO	Swallowing Problems	□YES	□NO
Heart Problems	□YES	□NO	Tracheostomy tube	□YES	□NO
Hypertension	□YES	□NO	Ventilator Dependency	□YES	□NO
High fevers	□YES	□NO	Visual Impairment	□YES	□NO

Adult SLP Case History- page 2/2 Name/Date of Birth: -_____

Other Medical History:

_____

_____

Surgeries (please list procedure/date):

_____

_____

Medications and dosage: _____

_____

Significant Family medical history: _____

_____

Family and Social History:

Primary Language □ English □Spanish □ Other: _____
Do you need an interpreter for your appointment: □YES □NO
Occupation: _____ □Student □Unemployed □Retired
Education: □College □High School □Last year completed: _____
Marital Status: □Single □Married □Divorced □Widowed
Children □Yes □NO Grandchildren □YES □NO
Members of Household: _____
Tobacco use: □YES □NO # of years_____ Packs per day: _____
Discontinued date: __/___/___
Alcohol intake: □YES □NO # of drinks per week _____
Do you have a substance dependency? □YES □NO
If yes, please explain:_____

Have you ever been examined or treated by the following?

		Name/Findings
Ear Nose and Throat Specialist	□YES □NO	_____
Eye Specialist	□YES □NO	_____
Neurologist	□YES □NO	_____
Psychiatrist/Psychologist	□YES □NO	_____
Speech/Language Pathologist	□YES □NO	_____
Neuropsychologist	□YES □NO	_____
Audiologist (Hearing Test)	□YES □NO	_____
Physical or Occupational Therapist	□YES □NO	_____
Other_____	□YES □NO	_____

Any other information that you feel would be important for us to know? _____

_____

_____

_____

Speech Pathologist's Signature Date/time