Stony Brook Medicine

Head and Neck Case History Attachment

Name: _____

Diagnosis (date/type) _____
Physician name and location: _____

Surgery plan: □ NO □ Yes date/type**: _____**
Radiation therapy plan : □ NO □ YES
Chemotherapy plan: □ NO □ YES

Previous radiation treatment: □ NO □ YES
If yes, Start date: _____ End date: _____ Reaction: _____
_____
Previous chemotherapy: □ NO □ YES
If yes, Start date: _____ End date: _____ Reaction: _____
_____
Current respiratory status: □ No difficulty □ Oxygen use □ Stoma (open hole in neck)
□ Trach tube (size and date placed) #_____

Dry Mouth: □ NO □ YES If yes, how do you manage it? _____
_____

Mucus/phlegm difficulty? □ NO □ YES If yes, how do you manage it?_____
_____

Current nutritional status?
Oral diet: □ Regular □ Cut up or soft solids □ Pureed □ Liquids only
Liquids: □ Regular/thin □ Nectar □ Honey
Tube feeding: □ NO □ YES amount and type:_____

Weight loss: □ NO □ YES **If yes, how many lbs._____, over_____weeks / months**

Any change in voice: □ NO □ YES **If yes, please circle all that apply:**
hoarse breathy too soft strained loss of voice
Current communication: □ Speech □ writing □ Electrolarynx
□ Gestures □ Communication/letterboard

Previous speech or swallowing evaluations/treatments: □ NO □ YES
Date, name, location and phone number:_____
_____