

Georgetown University Hospital Pediatric Feeding and Swallowing Evaluation

Pediatric History Questionnaire

This form has important questions that help the therapists understand your child. Please fill in all areas that you can. **Please bring any medical reports you have for our records.**

Form completed by: _____ Date Completed: _____

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____

Main language used at home: _____ Other languages used: _____

How were you referred to our facility? Dr. _____

What are your main concerns regarding your child's feeding/swallowing?

Family History

Please list your child's primary caregiver(s):

Name	Relationship to Child	Contact Numbers	Occupation
		Home: _____ Cell: _____ Work: _____	
		Home: _____ Cell: _____ Work: _____	
		Home: _____ Cell: _____ Work: _____	

Siblings/Other children in the home:

Name	Age	Grade in School	Developmental Delays?

Medical History

Biological Child Adoption Foster care

Pregnancy

- Complications: _____
- Medications taken during pregnancy: _____
- Prenatal exposure to alcohol tobacco drugs other: _____
- Maternal hospitalizations: because of _____
from _____ weeks gestation to _____ weeks gestation.
- Other: _____

Birth

Name of Hospital: _____ Length of Stay: _____
 Full Term Premature Post mature _____ weeks gestation
 Vaginal birth C-section Reason: _____
 Difficult Labor _____ Other: _____
 Birth Weight: _____ Apgar Scores: _____
 Complications: _____

Neonatal:

NICU Stay Hospital: _____ Length of Stay: _____
 Ventilator/Breathing Tube/Oxygen Difficulty Feeding
 Hearing Test Results: Pass Fail

Medical Diagnoses:

Has your child ever been given any of the following medical diagnoses? If yes, please list the date of diagnosis and the doctor who has followed/is following your child for the condition.

- Asthma _____
- Bronchopulmonary Dysplasia (BPD) _____
- Cerebral Palsy (CP) _____
- Chronic Colds/Respiratory Infections _____
- Chronic Lung Disease _____
- Cleft Lip and/or Cleft Palate _____
- Congenital Heart Disease _____
- Down Syndrome _____
- Failure to Thrive or Poor Weight Gain _____
- Hydrocephalus _____
- Interventricular Hemorrhages (IVH) Grade _____
- Laryngomalacia _____
- Periventricular Leukomalacia (PVL) _____
- Reflux/ Gastroesophageal Reflux Disease (GERD) _____
- Seizure Disorder _____
- Tracheomalacia _____
- Tracheostomy _____
- Vocal Cord Paralysis or Paresis _____
- Other: _____

Current Medical Status

Referring Physician: Name: _____ Phone: _____

Please list any **other doctors or specialists** involved in your child's care:

Please list all **medications** your child takes:

Medication	Purpose

Results of last **hearing** evaluation: _____ Date: _____
 Results of last **vision** evaluation: _____ Date: _____

Please list any additional hospitalizations since birth:

Age at Hospitalization	Reason	Length of Stay

Has your child had any **special tests or procedures**? If **yes**, please list date and results of the test/procedure. If you have copies of reports of any of the below medical procedures, please **bring them** with you to the evaluation.

- EEG _____
- Milk Scan _____
- MRI _____
- Nissen Fundoplication _____
- Upper Gastrointestinal (UGI) _____
- Other: _____

Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech language pathologist? _____

Development

Please write the **age** when your child first performed the following skills:

Sat alone: _____ Toilet-trained: _____
 Crawled: _____ Walked: _____
 Babbled: _____ Said a single word: _____
 Used a cup: _____ Fed him/herself: _____

Does your child use any special equipment at home or at school?

- Walker Wheelchair Special feeding utensils
- Assistive Technology Other: _____

Speech and Language

Please list any speech/language difficulties: _____

Feeding

How does your child currently receive nutrition? Check all that apply:

- NG-Tube NJ-Tube G-Tube
- Bottle (nipple type: _____) Sippy Cup
- Open Cup Spoon/Fork
- Straw Hands

If your child receives tube feedings, please complete the following:

Continuous Feeds: _____ cc/hour for _____ hours
Beginning time: _____ Ending Time: _____

Bolus Feeds: _____ cc/oz
Times Given: _____

What foods does your child currently take?

- | | |
|--|---|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Pureed Table Foods |
| <input type="checkbox"/> Formula | <input type="checkbox"/> Soft Chewables |
| <input type="checkbox"/> Stage 1 Baby Food | <input type="checkbox"/> Hard Chewables |
| <input type="checkbox"/> Stage 2 Baby Food | <input type="checkbox"/> Chewy foods |
| <input type="checkbox"/> Stage 3 Baby Food | <input type="checkbox"/> Pediasure |

How long does a meal (or for infants, a bottle) usually take? _____

Does your child display any of the following behaviors related to feeding?

- Frequent coughing/choking related to feeding
- Gagging/vomiting related to feeding
- Refusal behaviors (e.g. head turning) related to feeding
- Difficulty accepting foods of certain textures
- Difficulty chewing
- Holding food in mouth
- Other (please describe any difficulties related to feeding/swallowing):

Has your child had a swallow study by a speech pathologist? Yes No

If yes: Where: _____ When: _____

Results: _____

School or Early Intervention

School/Program: _____ Grade: _____

Support Services:

- | | |
|--|---|
| <input type="checkbox"/> Individual Family Service Plan (IFSP) | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Individual Education Plan (IEP) | <input type="checkbox"/> Assistive technology |
| <input type="checkbox"/> Adapted PE | <input type="checkbox"/> Speech therapy |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Classroom aide |
| <input type="checkbox"/> Other: _____ | |

Any concerns or difficulties? _____

Please add any other additional information you would like us to know about your child:

Please Note:

On the day of the evaluation, we would like to observe a typical feeding, so please try your best to bring your child somewhat hungry so that they will eat during the evaluation. Please also bring items your child typically uses at meals, such as spoons/utensils, bowls, cups, sippy cups, bottles, and foods (including foods that your child enjoys and foods that are difficult for your child).

If you have any questions, please feel free to call (202) 444-3690. Thank you! We look forward to meeting you and your child.