Blank Children's Hospital
UnityPoint Health

VIDEOSWALLOW CASE HISTORY

Please complete this form before your child's videoswallow.

Date: _____
Child's Name: _____ DOB: _____ Sex: ☐ M ☐ F
Person Completing Questionnaire: _____
Relationship to child: _____ Phone: _____

Prenatal and Birth History:

During this pregnancy, did the child's mother experience any unusual illness, condition or accident: ☐ Yes ☐ No
If yes, please provide information: _____
Was there drug/alcohol use during pregnancy? ☐ Yes ☐ No If yes, please describe: _____
Length of Pregnancy: _____ Type of Delivery: ☐ Cesarean ☐ Vaginal
Child's Birth Weight: _____ Hospital Stay following birth: _____
Was infant in the Intensive Care Nursery? ☐ Yes ☐ No For how long? _____
Were any of the following present after birth?
Seizure Activity: ☐ Yes ☐ No Difficulty regaining birth weight: ☐ Yes ☐ No
Difficulty sucking/swallowing: ☐ Yes ☐ No Need for oxygen: ☐ Yes ☐ No

Medical Information:

Primary Physician/Practitioner: _____ Phone: _____
Referring Physician: _____ Phone: _____
Medical Diagnosis: _____
List Reason for Referral: _____

Has your child had any of the following tests?

Upper GI:
When/Where: _____
Results: _____

Swallow Study:
When/Where: _____
Results: _____

Endoscopy:
When/Where: _____
Results: _____

Nuclear Med/Gastric Emptying:
When/Where: _____
Results: _____

pH Probe:
When/Where: _____
Results: _____

Has your child had? (check all that apply):

☐ Frequent colds ☐ Bronchitis ☐ Asthma ☐ Bronchiomalacia
☐ Tracheaomalacia ☐ Laryngomalacia ☐ Bronchopulmonary Dysplasia
☐ Use of Oxygen ☐ Tracheostomy (if yes, date placed: _____ date removed: _____)

Therapeutic History:

Does your child receive: ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy
Where: _____ How often: _____
Therapist(s): _____
*Release of Information will need to be signed to provide information from this video to these individuals.

Patient Label

Nutrition and Feeding:

1. Does your child have difficulty gaining weight? ☐ Yes ☐ No
2. Have there been any past or present nutritional concerns? ☐ Yes ☐ No
3. Does or has your child have/had (check all that apply):
   - ☐ G-tube or J-tube: Start: _____ Stop: _____
   - ☐ Nasogastric tube: Start: _____ Stop: _____
   - ☐ Oral-Gastric tube: Start: _____ Stop: _____

   Why were the tubes placed? _____
4. Is your child drinking from (check all that apply):
   - Breast: ☐ Yes ☐ No How often? _____ How long on each breast? _____
   - Bottle: ☐ Yes ☐ No How often? _____ How many ounces per feeding? _____
     Length of time to take bottle? _____ Nipple used? _____
   - Cup: ☐ Yes ☐ No How often? _____ How many ounces per feeding? _____
   - Does your child know how to use a straw? ☐ Yes ☐ No
   - Do you need to assist with cup drinking? ☐ Yes ☐ No
5. Please list food your child particularly likes or that is easy for him/her to handle: _____

   _____
6. Please list foods your child particularly dislikes or cannot eat well. Describe why they are difficult for your child:

   _____

   _____

Positions and Equipment for Feeding:

1. What position do you typically use for feeding your child? (check all that apply):
   ☐ Sitting on your lap ☐ Reclined in your arms ☐ High Chair ☐ Booster Seat ☐ Adapted Chair
   ☐ Other: _____
2. Are there any adaptations used to help your child maintain a correct sitting position? ☐ Yes ☐ No (check all that apply)
   ☐ Bolster ☐ Seat insert ☐ Chest strap ☐ Lap tray ☐ Head support ☐ Hip strap
   ☐ Other: _____
3. Can your child do any of the following? (check all that apply):
   - Hold head up alone? ☐ Yes ☐ No Since age: _____
   - Roll? ☐ Yes ☐ No Since age: _____
   - Crawl? ☐ Yes ☐ No Since age: _____
   - Sit alone? ☐ Yes ☐ No Since age: _____
4. Do you let your child get messy with foods while they are eating? ☐ Yes ☐ No
   If yes, does your child enjoy this or fuss with being messy? ☐ Enjoy ☐ Fuss
   Do you, as the parent, have trouble letting your child get messy with foods? ☐ Yes ☐ No
5. Does your child suck on his/her pacifier? ☐ Yes ☐ No
6. Does your child feed him/herself? ☐ Yes ☐ No
7. On a scale of 1 to 10 (1 being the least stressed and 10 being the most stressed), how would you rate your level of stress in relationship to your child's feeding? (please check the appropriate number):

   (Least stressed) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Most stressed)

*Thank you for your time and input. Please remember to return in the enclosed envelope, fax to 515-241-8696, or bring with you. We look forwarding to meeting your child and you.

Patient Label