

# Dysphagia Evaluation

## Patient information

Name:

Age:

Gender:

Date of evaluation:

Medical history:

## Symptoms

Description of symptoms:

Duration of symptoms:

Severity of symptoms:

## Patient history

Underlying medical conditions:

Medications:

Allergies:

History of smoking/alcohol use:

**Physical examination**

Oral cavity inspection:

Neck examination:

Neurological assessment:

**Diagnostic test findings**

Videofluoroscopic Swallow Study (VFSS):

Endoscopy:

Esophageal manometry:

pH monitoring:

**Clinical assessment**

Clinical indicators:

Severity of dysphagia:

Likely cause:

**Additional notes**

Doctor in-charge:

Signature:

Date: