How to Submit History

THE UNIVERSITY OF SOUTH CAROLINA
SPEECH AND HEARING RESEARCH CENTER
1601 ST. JULIAN PLACE
MIDDLEBURG OFFICE PARK
COLUMBIA, SC 29204
Phone: 803-777-2614 Fax: 803 253-4243

ADULT SPEECH-LANGUAGE HISTORY

Date: ____________________ Referred by ______________________________

Physician's name ______________________________

Person completing this form ______________________________

Relationship to client ______________________________

Patient Name ____________________ Birth date ____________________ Age ______________

Address: ______________________________ City/State: ____________________ Zip: __________

County of Residence ____________________ Email address: ______________________________

Phone (home) ____________________ (work)____________________ (cell) ____________________

Occupation (or if retired, previous occupation) ______________________________

Date of Retirement:________________ Race/Ethnicity:___________ Highest level of Education: ________

HEALTH HISTORY

____________________	____________	____________________	____________
Primary Doctor	Phone Number	ENT	Phone Number
Neurologist	Phone Number	Cardiologist	Phone Number

Have you had a hearing evaluation? ☐ Yes ☐ No Name of audiologist: ______________________

Reported results ____

Check all that apply to you and provide date of onset:	YES	NO	Onset date:
Allergies	☐	☐	____________
Anoxia or other breathing difficulties	☐	☐	____________
Asthma	☐	☐	____________
Cancer	☐	☐	____________
Dental problems	☐	☐	____________
Diabetes	☐	☐	____________
Epilepsy/seizures	☐	☐	____________
Frequent colds	☐	☐	____________
Head Injury	☐	☐	____________
Hearing problems	☐	☐	____________
Heart Condition	☐	☐	____________
High Blood Pressure	☐	☐	____________
Low Blood Pressure	☐	☐	____________

HEALTH HISTORY (continued)	YES	NO	Onset date:
Pneumonia	☐	☐	____________
Paralysis	☐	☐	____________
Stroke	☐	☐	____________
Stuttering	☐	☐	____________
Surgeries	☐	☐	____________
Swallowing difficulties	☐	☐	____________
Thyroid Condition	☐	☐	____________
Tube feeding	☐	☐	____________
Virus Infection	☐	☐	____________
Vision problems	☐	☐	____________

OTHER RELATED HISTORY:	YES	NO	When?
Extended hospitalization	☐	☐	____________ through ____________
Surgeries/ invasive procedures	☐	☐	____________ through ____________
Tobacco Use	☐	☐	____________ through ____________
Do you have any metal implants?	☐	☐	e.g., (pacemaker, metal heart valve, stent, aneurysm clip, intrauterine device, artificial joints)

For all conditions marked "yes" please provide more information [e.g., type, treatment, etc.]: ________________

____

____

____

Please list any other conditions: ____

____

Handedness (Right or Left) for: ______Writing ______Throwing ______Eating

Services currently received:
- ☐ Speech Therapy
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Vocational Rehabilitation

MEDICATIONS: Please list **name** and **dosage** of all medications you are currently taking and for **what illness** the medicine is prescribed [include over-the counter medications, oxygen, inhalers, vitamins, and herbals.]

Name of Medicine/Dosage	Illness/condition	Name of Medicine/Dosage	Illness/condition
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Do you have any allergic reactions? If so what are your symptoms? ______________________________

____

SOCIAL HISTORY

Single ☐ Widowed ☐ Divorced ☐ Spouse/ Primary Caregiver's Name: ____________________________

Who lives in the home with you? ____

List other languages spoken in the home____

Does your job or hobbies require use of your voice? ____

____

Indicate any family history of the following speech, language, hearing or learning difficulties:

	YES	NO	Relationship
Difficulty producing a few sounds	☐	☐	____________________
Speech difficult to understand by others	☐	☐	____________________
Stuttering	☐	☐	____________________
Hearing loss	☐	☐	____________________
Learning disability	☐	☐	____________________
Reading	☐	☐	____________________
Writing	☐	☐	____________________
Spelling	☐	☐	____________________
Difficulty understanding spoken language	☐	☐	____________________
Genetic disorder	☐	☐	____________________

Name of genetic disorder: ____

Describe your communication difficulty: ____

____

____

When did you first notice a change in your communication skills? ________________________________

____

____

Has your communication problem changed since its onset? ☐ Yes ☐ No

If so, how has it changed? ____

____

Does your problem change throughout a single day? ☐ Yes ☐ No

If so, how does it change? ____

____

What are your current and/or future vocational goals? ______________________________________

____

Have you had speech therapy before this? ☐ Yes ☐ No. Was it helpful? ☐ Yes ☐ No

What do you hope to gain from speech therapy at this time in your life? ______________________________

____

What questions would you like answered? ____

____

Please complete this and either fax it to our office [803-253-4143] or mail it to us [1601 St. Julian Place, Columbia, SC 29204] prior to your scheduled evaluation. Thank you!