Instructions for Flexible Endoscopy Exam of Swallowing (FEES)

You have been referred to the Speech Pathologist to have a swallow test. The FEES test is an endoscopic test that is both an evaluation and a rehabilitation study.

It is designed to:

- Look at the basic anatomy of your throat and vocal cords during the act of swallowing;
- Observe food/liquid moving through your throat when you swallow;
- Identify any possible compensatory and/or therapeutic procedures that can effectively and efficiently improve your swallow.

This swallow study is performed with you sitting in an upright position on either a stool or in your wheelchair. Small amounts of food and liquid will be given to you to eat and drink. Food coloring may be added so the food can be seen as it passes through your throat.

Results will be discussed immediately following the exam with recommendations provided. Additional therapy sessions may be recommended to learn exercises that will improve your swallowing ability. A follow up appointment with the referring doctor should be made to discuss the results and recommendations with him/her.

SPECIAL ATTENTION NEEDS TO BE MADE OF THE FOLLOWING DIRECTIONS:

1. Fasting WILL NOT be required for this examination.
2. If you are having a problem with certain food, **please bring a small portion** of the food(s) with you to the study.
3. Please fill out a swallowing questionnaire (also available at the front desk) and bring it with you completed. Please have it ready by your appointment time.

PROCEDURES FOR DAY OF EXAM:

Arrive 15 minutes early to ensure all necessary paperwork is completed.

- ✓ Appointment will be at the MARC, ENT Suite 6-B
- ✓ Check in for the swallowing study with Jill Green.
- ✓ Request swallow questionnaire if you have not already completed it.
- ✓ Wait to be called in for the study.

If you are not able to keep your appointment, notify us as soon as possible at (210) 450-9950.

University of Texas Voice Center

Patient Questionnaire for Swallowing Problems

Name: **Date:**

EAT-10 **0 = no problem** **4 = severe problem**					
My swallowing problem has caused me to lose weight.	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals.	0	1	2	3	4
Swallowing liquids takes extra effort.	0	1	2	3	4
Swallowing solids takes extra effort.	0	1	2	3	4
Swallowing pills takes extra effort.	0	1	2	3	4
Swallowing is painful.	0	1	2	3	4
The pleasure of eating is affected by my swallowing.	0	1	2	3	4
When I swallow food sticks in my throat.	0	1	2	3	4
I cough when I eat.	0	1	2	3	4
Swallowing is stressful.	0	1	2	3	4

What bothers you about your swallowing?	
When did this begin?	
How frequently does it occur? **Example: every time you eat; 1x/day; 1x/week; 1x/month**	
What is most difficult to swallow? **Example: type of foods, liquids, pills**	
Do you avoid foods or liquids? **If so, what specifically?**	
Do you have other medical problems/diagnoses that affect your swallow?	
How much of these do you drink per day?	**Water_____ Caffeine_____ Carbonation _____**
Check any of the following that apply to you…	**____Pacemaker; ____ICD;** **____Deep Brain Stimulator;** **____Vagal Nerve Stimulator;** **____ Implanted Metal** **____ Surgeries: _____**

University of Texas Voice Center

Patient Questionnaire for Swallowing Problems

Check any conditions that apply to you…	**____ Pregnant;** **____Hx of chemo and/or radiation therapy; when completed?_____** **____History of seizures, epilepsy**
List ALLERGIES:	
What types of foods do you typically eat?	**Check all that apply:** **_____Regular diet, avoid nothing** **_____Soft solids** **_____Mainly Pureed foods** **_____Diabetic diet,** **_____PEG, J-tube** **_____No liquids** **_____No pills by mouth**

Symptom	Circle:	Describe if applicable:
Pain on swallowing	**Yes / No**	**Where?** **When?**
Problems chewing	**Yes / No**	
Does food/liquid spill out from your lips?	**Yes / No**	
Dry mouth	**Yes / No**	
Do you have to use liquids to "wash" items through mouth or throat?	**Yes / No**	
Are there food pieces left in mouth after swallowing?	**Yes / No**	
Increased saliva/secretions?	**Yes / No**	
Do you have difficulty managing saliva?	**Yes / No**	
Do any of the following happen during or after eating/drinking ?	**Coughing, Choking, Wet voice**	***Circle the ones that apply.*** **Does it occur after swallowing? Y N** **At times not related to food/liquid? Y N**

University of Texas Voice Center

Patient Questionnaire for Swallowing Problems

Slowed eating time?	Yes / No	Do you fatigue during meals? Y N
Poor appetite	Yes / No	Do you enjoy eating?
Frequent bronchitis or upper respiratory infections?	Yes / No	How many per year? _____
Weight loss?	Yes / No	How much?_____ Time period _____
Food "sticks"	Yes / No	High in throat? Y N Low in throat Y N
Food coughed up?	Yes / No	When?
Nasal regurgitation?	Yes / No	
Heartburn/reflux?	Yes / No	When?
Throat clearing?	Yes / No	During meals? Y N At other times not related to meals? Y N
Eating till overly full?	Yes / No	
Eating within 2 hours of lying down?	Yes / No	
Voice and Speech changes?	Yes / No	*Check all that apply:* _____Hoarseness, _____Gurgly/wet voice, _____ Slurred articulation (speech sounds)
Ever smoked?	Yes / No	Packs per day _____, How many years _____, When quit _____
Alcohol use?	Yes / No	How often_____, When quit_____
Dentures?	Yes / No	
Gum Disease?	Yes / No	
What do you do to improve swallowing currently?		
Any prior swallow tests? When? What did they tell you?		