



Sydney Swallow Questionnaire



Name: _____

DOB/Sex: _____

Date: _____

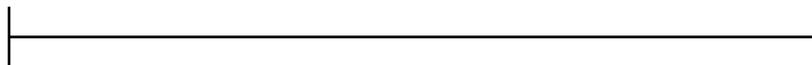
This questionnaire is designed to help us establish the severity of your swallowing problem. It is quite straightforward and should easily be completed within 10 minutes. All the information given will remain **strictly confidential**.

For each question put an "X" on the line below to indicate how severe your swallowing problem is. For example. Put the "X" towards the **lefthand end** of the line if your problem is only **minor**, in the **middle** if it is **moderate** and at the **righthand end** if you have **severe** difficulty. If you have NO problem or difficulty asked about in the question you should place "X" at the **FAR LEFTHAND** end of the line.

1. How much **difficulty** do you have swallowing at **present**?

NO DIFFICULTY
AT ALL

UNABLE TO SWALLOW
AT ALL



2. How much difficulty do you have **swallowing THIN liquids?**
(eg: tea, soft drink, beer, coffee)

NO DIFFICULTY
AT ALL

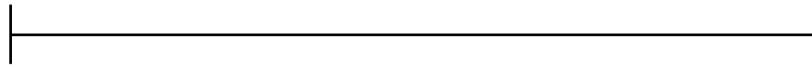
UNABLE TO SWALLOW
AT ALL



3. How much difficulty do you have **swallowing THICK liquids?**
(eg: milkshakes, soups, custard)

NO DIFFICULTY
AT ALL

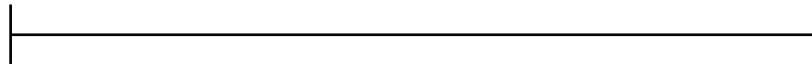
UNABLE TO SWALLOW
AT ALL



4. How much difficulty do you have **swallowing SOFT foods?**
(eg: mornays, scrambled egg, mashed potato)

NO DIFFICULTY
AT ALL

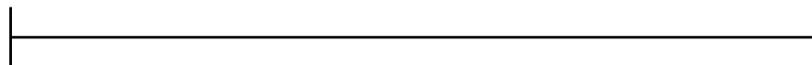
UNABLE TO SWALLOW
AT ALL



5. How much difficulty do you have **swallowing HARD foods?**
(eg: steak, raw fruit, raw vegetables)

NO DIFFICULTY
AT ALL

UNABLE TO SWALLOW
AT ALL



6. How much difficulty do you have **swallowing DRY foods?**
(eg: bread, biscuits, nuts)

NO DIFFICULTY
AT ALL

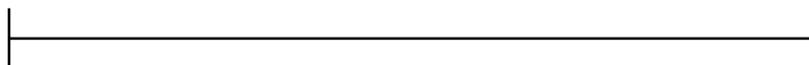
UNABLE TO SWALLOW
AT ALL



7. Do you have any difficulty **swallowing your saliva?**

NO DIFFICULTY
AT ALL

UNABLE TO SWALLOW
AT ALL



8. Do you have any difficulty **starting a swallow?**

NEVER
OCCURS

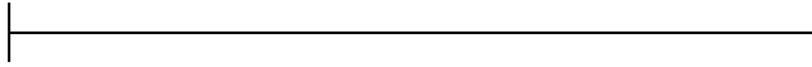
OCCURS EVERY TIME
I SWALLOW



9. Do you ever have a **feeling of food** getting **stuck** in your throat when you swallow?

NEVER
OCCURS

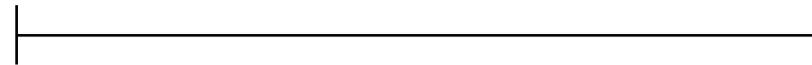
OCCURS EVERY TIME
I SWALLOW



10. Do you ever **cough or choke** when swallowing **solid foods**?
(eg: bread, meat or fruit)

NEVER
OCCURS

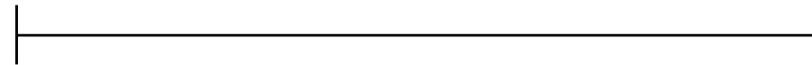
OCCURS EVERY TIME
I EAT



11. Do you ever **cough or choke** when swallowing **liquids**?
(eg: coffee, tea, water, beer)

NEVER
OCCURS

OCCURS EVERY TIME
I DRINK



12. How long does it take you to **eat an average meal**?
Please **TICK ONE.**

Less than **15** minutes _____

About **15-30** minutes _____

About **30-45** minutes _____

About **45-60** minutes _____

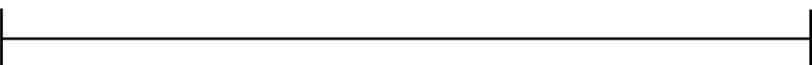
More than **60** minutes _____

Unable to swallow at all _____

13. When you swallow does food or liquid **go up behind your nose or come out of your nose**?

NEVER
OCCURS

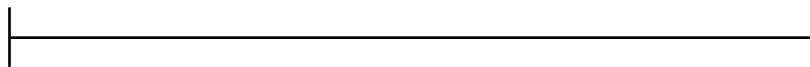
OCCURS EVERY TIME
I SWALLOW



14. Do you ever need to **swallow more than once** for your food to go down?

NEVER
OCCURS

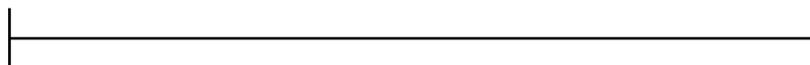
OCCURS EVERY TIME
I SWALLOW



15. Do you ever **cough up or spit out food or liquids** DURING a meal?

NEVER
OCCURS

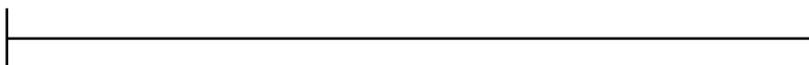
OCCURS EVERY TIME
I EAT OR DRINK



16. How do you rate the **severity of your swallowing problem today?**

NO
PROBLEM

EXTREMELY SEVERE
PROBLEM



17. How **much** does your swallowing problem **interfere with your enjoyment or quality of life?**

NO
INTERFERENCE

EXTREME
INTERFERENCE



THANK YOU FOR YOUR ASSISTANCE

Investigator Note:

1. Details of the development, validation and recommended analysis of the Sydney Swallow Questionnaire can be found in: Wallace KL, Middleton S and Cook IJ, Gastroenterology 2000; 118: 678-687
2. Questionnaire and related documentation available at website:
<http://www.stgeorgeswallowcentre.org/ssq>

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