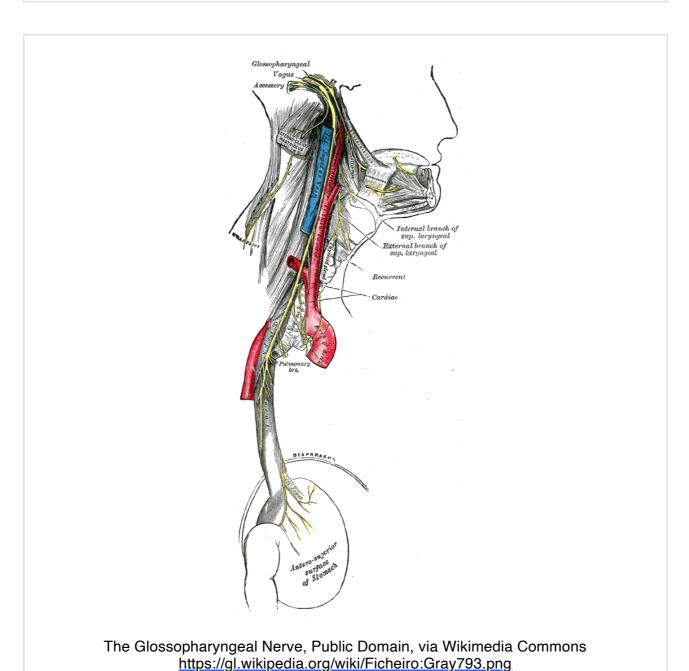
## **Glossopharyngeal Nerve Test Form**

## **Patient Information:**

Patient Name:	Patient Name:
Date of Birth:	Date of Birth:
Patient ID:	Patient ID:
Healthcare Provider:	Healthcare Prov
Date of Test:	Date of Test:



## **Glossopharyngeal Nerve Test Procedures:**

Taste Sensation Test:
<b>Instructions:</b> Apply different taste solutions (sweet, sour, bitter) to the posterior third of the tongue.
Observations:
□ Normal taste perception
☐ Reduced/absent taste perception
Comments:
Gag Reflex Test:
Instructions: Gently stimulate the back of the throat on each side.
Observations:
☐ Normal gag reflex
☐ Diminished gag reflex
☐ Absent gag reflex
Comments:
Swallowing Ability Test:
Instructions: Ask the patient to swallow a small amount of water.
Observations:
☐ Swallows without difficulty
☐ Difficulty swallowing
☐ Unable to swallow
Comments:

## **Glossopharyngeal Nerve Test Results**

<b>Test Component</b>	Result	Notes
Taste Sensation	□ Normal	
	Reduced	
	☐ Absent	
Gag Reflex	☐ Normal	
	☐ Diminished	
	☐ Absent	
Swallowing Ability		
	☐ Difficulty	
	☐ Unable	
Patient History:		
Previous Neurological Cond	ditions:	

Previous Neurological Conditions:
Current Medications:
History of Throat or Neck Surgery:

Allergies (especially related to taste or salivation):
Comments:
Additional Information:
Current Symptoms:
Duration of Symptoms:
Impact on Daily Activities:
Comments: