Heartburn / Acid Reflux Questionnaire

If you have heartburn, acid reflux or take medication for those conditions, please complete this 6- question GERD (GastroEsophageal Reflux Disease) Health Related Quality of Life Questionnaire:

Scale:
0= No Symptoms
1= Symptoms noticeable, but not bothersome
2= Symptoms bothersome 2 or more times per week
3= Symptoms are incapacitating, unable to do daily activities

Questions: (circle one)

1.	How bad is your heartburn?	0	1	2	3
2.	Heartburn when lying down?	0	1	2	3
3.	Heartburn after meals?	0	1	2	3
4.	Does heartburn wake you from sleep?	0	1	2	3
5.	Do you have difficulty swallowing?	0	1	2	3
6.	Do you have pain with swallowing?	0	1	2	3

IF YOU SCORED 2 or HIGHER ON ANY OF THE ABOVE, YOU SHOULD TALK TO YOUR HEALTHCARE PROVIDER ABOUT YOUR SYMPTOMS AND POSSIBLE COMPLICATIONS FROM YOUR ACID REFLUX.

How satisfied are you with your current condition: Satisfied Neutral Dissatisfied

Are you currently taking any medications for heartburn or GERD? Yes No

--If Yes, please indicate any Rx or over the counter meds (zantac, tums etc):_____

Have you seen a Gastroenterologist for this condition? Yes, MD's name here:_____

Have you ever been diagnosed with Barrett's Esophagus? No Yes - year first diagnosed:_____

Current Primary Physician:_____

IF YOU WOULD LIKE SOMEONE TO CONTACT YOU REGARDING YOUR CONDITION, PLEASE LET US KNOW HOW YOU'D LIKE TO BE CONTACTED:

NAME:_____ PHONE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

EMAIL:_____