Heartburn/Reflux Symptoms Questionnaire

Date of Visit: _____
Date of Birth: _____

Patient Name: _____
Regarding your symptoms over the past 7 days:
Were you on anti-reflux medication? ☐YES ☐NO

Check Column 1= symptoms OFF meds; Column 2 = ON
(may estimate past symptoms off reflux meds if not recent)

1. How often did you have a burning feeling behind your breastbone (heartburn)?

OFF	**ON** (Medication)	
☐	☐ 0 days	(0)
☐	☐ 1 day	(1)
☐	☐ 2-3 days	(2)
☐	☐ 4-7 days	(3)

2. How often did you feel the unpleasant sensation of stomach contents (food or liquid) move upwards into your throat or mouth (regurgitation)?

OFF	**ON** (Medication)	
☐	☐ 0 days	(0)
☐	☐ 1 day	(1)
☐	☐ 2-3 days	(2)
☐	☐ 4-7 days	(3)

3. How often did you have pain in the center of the upper stomach region?

OFF	**ON** (Medication)	
☐	☐ 0 days	(0)
☐	☐ 1 day	(1)
☐	☐ 2-3 days	(2)
☐	☐ 4-7 days	(3)

4. How often did you have nausea?

OFF	**ON** (Medication)	
☐	☐ 0 days	(0)
☐	☐ 1 day	(1)
☐	☐ 2-3 days	(2)
☐	☐ 4-7 days	(3)

5. How often did you have difficulty getting a good night's sleep because of your heartburn and/or regurgitation?

OFF	**ON** (Medication)	
☐	☐ 0 days	(0)
☐	☐ 1 day	(1)
☐	☐ 2-3 days	(2)
☐	☐ 4-7 days	(3)

6. How often did you take additional medications for your heartburn and/or regurgitation (such as Tums, Pepcid, Prilosec, etc.)?

OFF	**ON** (Medication)	
☐	☐ 0 days	(0)
☐	☐ 1 day	(1)
☐	☐ 2-3 days	(2)
☐	☐ 4-7 days	(3)

TOTAL: _____

Add up your corresponding score. Those who have a score of 8 or greater have a high likelihood of having Gastroesophageal Reflux Disease. Those with total scores of fewer than 8 have low or no likelihood of GERD.

Within the last MONTH, how did the following problems affect you? (Refer to Scoring Scale)
Circle responses: 0= No problem.....5= Severe problem

Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess mucous in throat or postnasal drip	0	1	2	3	4	5
Difficulty swallowing food, liquid or pills	0	1	2	3	4	5
Coughing after eating or lying down	0	1	2	3	4	5
Breathing difficulty or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up into your throat	0	1	2	3	4	5

TOTAL:_____
(A score of 15 or more means that you have a 90% chance of having reflux, especially airway reflux.)

(over ->)

GERD-HRQL Questionnaire

Please check the number that best reflects your symptoms using the scoring scale provided below.

Circle only one number for each question.
Scoring Scale:
0 = No symptoms
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome every day
4 = Symptoms affect daily activities
5 = Symptoms are incapacitating – unable to do activities]

How bad is your heartburn?	0	1	2	3	4	5
Heartburn when lying down	0	1	2	3	4	5
Heartburn when standing up	0	1	2	3	4	5
Heartburn after meals?	0	1	2	3	4	5
Does heartburn change your diet	0	1	2	3	4	5
Does heartburn wake you from sleep?	0	1	2	3	4	5
Do you have difficulty swallowing?	0	1	2	3	4	5
Do you have bloating or gassy feelings?	0	1	2	3	4	5
Do you have pain with swallowing?	0	1	2	3	4	5
If you take medication, does this affect daily life?	0	1	2	3	4	5

GERD-HRQL Total_____

How satisfied are you with your present condition? ☐ Satisfied ☐ Neutral ☐ Dissatisfied