

GI Excellence, Inc.

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GI EXCELLENCE GERD QUESTIONAIRE FORM

If you have heartburn or GERD or take medication for those conditions, please complete this 10- question GERD Health Related Quality of Life Questionnaire:

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 daily activities

~ Phone call ~

Questions: (circle one)							
1.	How bad is your heartburn?	0	1	2	3	4	5
2.	Heartburn when lying down?	0	1	2	3	4	5
3.	Heartburn when standing up?	0	1	2	3	4	5
4.	Heartburn after meals?	0	1	2	3	4	5
5.	Does heartburn change your diet?	0	1	2	3	4	5
6.	Does heartburn wake you from sleep?	0	1	2	3	4	5
7.	Do you have difficulty swallowing?	0	1	2	3	4	5
8.	Do you have pain with swallowing?	0	1	2	3	4	5
9.	Do you have bloating or gassy feelings?	0	1	2	3	4	5
10. If you take medications, does this affect your daily life? O 1 2 3 4 5 TOTAL Score (enter total here - 50 points max.)							
How satisfied are you with your current condition: SatisfiedNeutral Dissatisfied							
Are you currently taking any medications for heartburn or GERD? Yes No							
First Name: Last Name:							
Phone: Email:							
Address:							
City: State: Zip code: How would you like to be followed up with? (Circle below)							

~ Schedule an Appointment ~

GI EXCELLENCE GERD OUESTIONAIRE FORM

~ Email with information ~