

GERD-Health Related Quality of Life Questionnaire

Patient Name:			Date:
On PPI:	☐ Yes ☐ No If dis	scontinued PPI, for how long:	
Scale:			
0-	No Symptom		
1-	Symptoms noticeable but not bothersome		
2-	Symptoms noticeable and bothersome but not every day		
3-	Symptoms bothersome every day		
4-	Symptoms affect daily activity		
5-	Symptoms are incapacitating to do daily activities		
Please v	vrite the number descri	bing your experience over the	past 2 weeks next to each question.
1.	How bad is the heartburn?		
2.	Heartburn when lying		
3.	Heartburn when standing up?		
4.	. Heartburn after meals?		
5.	Does heartburn change your diet?		
6.	Does heartburn wake you from sleep?		
7.	Do you have difficulty swallowing?		
8.			
9.	If you take medication, does this affect your daily life?		
). How bad is the regurgitation?		
11.	Regurgitation when lying down?		
12.	Regurgitation when standing up?		
	Regurgitation after meals?		
14.	4. Does regurgitation change your diet?		
Does regurgitation wake		ke you from sleep?	
16.	How satisfied are you with your present condition?		
	☐ Satisfied	☐ Neutral	☐ Dissatifised
Scale:			
0-	No problem		
5-	Severe Problem		
Please v	vrite the number descri	bing your experience over the	past month next to each question.
1.	Hoarseness or a problem with your voice?		
2.	Clearing your throat?		
3.	Excess throat mucus or postnasal drip?		
4.	Difficulty swallowing food, liquids, or pills?		
5.	Coughing after you ate or lay down?		
6.	Breathing difficulties or choking episodes?		
7.	Troublesome or annoying cough?		
8.	Sensations of something sticking in your throat?		
9.	Heartburn, chest pain, indigestion, or stomach acid coming up?		

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