Esophageal Institute of Atlanta
2045 Peachtree Road NE, Suite 310
Atlanta, GA 30309

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Please complete the following survey to indicate the severity of your GERD symptoms.

You can complete this form on your computer, save the completed form and return as an email attachment, or print the form, complete and scan and reuturn via email as attachement, or mail to Esophageal Institute of Atlanta.

Please indicate below your GERD medication usage:

Name(s) of last GERD medication(s) used:

Dosage(s) of GERD medications:

Date of last dose of GERD medication(s):

GERD-HRQL Questionnaire

PLEASE CHECK THE NUMBER THAT BEST REFLECTS YOUR SYMPTOMS USING THE SCORING SCALE PROVIDED BELOW.
CHECK ONLY ONE BOX FOR EACH QUESTION.

Scoring Scale		
0 = No symptoms		**3** = Symptoms bothersome every day
1 = Symptoms noticeable but not bothersome		**4** = Symptoms affect daily activities
2 = Symptoms noticeable and bothersome but not every day		**5** = Symptoms are incapacitating, unable to do activities

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 bloating or gassy feelings?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Do you have pain with swallowing?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. If you take medication, does this affect your daily life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
					GERD-HRQL Total _____	

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