REFLUX SYMPTOM INDEX

Within the last MONTH, how did the following problems affect you?

0 = no problem, 5 = severe problem

1.	Hoarseness or a problem with your voice	1	2	3	4	5
2.	Clearing your throat	1	2	3	4	5
3.	Excess throat mucous or postnasal drip	1	2	3	4	5
4.	Difficulty swallowing food, liquids, or pills	1	2	3	4	5
5.	Coughing after you ate or after lying down	1	2	3	4	5
6.	Breathing difficulties or choking episodes	1	2	3	4	5
7.	Troublesome or annoying cough	1	2	3	4	5
8.	Sensations of something sticking in your throat or a lump in your throat	1	2	3	4	5
9.	Heartburn, chest pain, indigestion, or stomach acid coming up	1	2	3	4	5
	Total					5

THE GASTROESOPHAGEAL REFLUX DISEASE HEALTH RELATED QUALITY OF LIFE INSTRUMENT

Please check the numeric assessment of your GERD symptoms using the scoring provided below. Check only one box 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

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

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