Baylor Scott & White
CENTER FOR ESOPHAGEAL DISEASES
A member of HealthTexas Provider Network

Patient Name: _____
Patient DOB: _____
Date: _____

Health History Questionaire

If you are a new patient, please fill out the section below. Otherwise, you may skip to the next section.

Who referred your consultation? _____

If no one referred you, how did you hear about us? _____

Who is your primary care physician? _____

Have you ever seen a gastroenterologist ? Please list their name(s).

- ☐ Yes, I am under the care of a gastroenterologist. _____
- ☐ Yes, I have seen one in the past, but not currently. _____
- ☐ No, I have never seen a gastroenterologist.

Have you recently experienced any of the following? (Please check all that apply)

- ☐ Trouble Swallowing
- ☐ Food Gets Stuck
- ☐ Choking
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Regurgitation
- ☐ Belching
- ☐ Fevers or chills
- ☐ Fatigue
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurry Vision
- ☐ Double vision
- ☐ Hearing changes
- ☐ Weight Loss
- ☐ Weight gain
- ☐ Change in appetite
- ☐ Feeling full early
- ☐ Sore Throat
- ☐ Voice Hoarseness
- ☐ Congestion
- ☐ Throat Clearing
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Yellowing of eyes or skin
- ☐ Skin rashes or lumps
- ☐ Abdominal Bloating
- ☐ Abdominal pain
- ☐ Recent change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Tar-like stools
- ☐ Bleeding from rectum
- ☐ Vomiting Blood
- ☐ Heat or cold intolerance
- ☐ Trouble with urination
- ☐ Frequency of urination
- ☐ Joint pain or swelling
- ☐ Recent mood changes
- ☐ Memory changes
- ☐ Frequently anxious

Have you ever been treated for or had issues with any of the following? (Please check all that apply)

- ☐ Cancer : _____
- ☐ Hay fever
- ☐ Food allergies
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Valvular heart disease
- ☐ Congestive Heart Failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema or Bronchitis
- ☐ Other lung disease
- ☐ Ulcers
- ☐ Chronic Diarrhea
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Irritable or spastic colon
- ☐ Colitis
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Other Liver Disease
- ☐ Genital Disorders
- ☐ Prostate Trouble
- ☐ Endometriosis
- ☐ Back/Spinal problems
- ☐ Kidney Stones
- ☐ Other Kidney Problems
- ☐ Goiter or thyoird trouble
- ☐ Diabetes
- ☐ Anemia (low blood count)
- ☐ Blood clot in lungs or legs
- ☐ Other blood disorders
- ☐ Poor Circulation
- ☐ Arthritis
- ☐ Stroke
- ☐ Seizures
- ☐ Depression or Anxiety

Patient Name: _____
Patient DOB: _____

Have you ever had the following operations? (Please check all that apply)

- □ Removal of gallbladder
- □ Fundoplication
- □ Antireflux surgery
- □ Hiatal hernia repair
- □ Gastric sleeve
- □ Gastric bypass
- □ Lap Band placement
- □ Myotomy for Achalasia
- □ Removalof stomach (part or all)
- □ Removal of appendix
- □ Hemorrhoid Surgery
- □ Removal of part/all of colon
- □ Removal of Spleen
- □ Heart Bypass
- □ Angioplasty
- □ Removal of Kidney
- □ Inguinal hernia repair
- □ Artificial blood vessel graft
- □ Replacement of Heart Valve
- □ Tonsillectomy
- □ Prostate surgery
- □ Hysterectomy
- □ Ovearies Removed
- □ Tubes tied
- □ Placement of artificial joint
- □ Eye Surgery
- □ Any other surgery on the esophagus or stomach

Please list any other medical conditions or operations:

Please circle yes or no for each of the following questions.

Are you on medications for diabetes?	Yes	No
Are you on steroids?	Yes	No
Are you on any blood thinners ?	Yes	No
Are you currently taking an acid suppression tablet regularly?	Yes	No
Have you ever been told you have a difficult airway or intubation?	Yes	No
Have you ever had a problem with anesthesia. Please explain.	Yes	No
Do you have sleep apnea or do you currently use a CPAP machine?	Yes	No

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DIET SURVEY

NAME: _____ DATE: _____

Please give us an overall idea of what you typically eat and drink. If it is variable, please just give your best idea.

How many meals a day do you eat?_____

What do you typically eat and when do you eat your meals and snacks? Please fill out table as best you can. You may also just write down what you ate during the last 24 hours.

	Typical timing	Typically what you eat	Check if not applicable
Typical Breakfast			
Typical Lunch			
Typical Dinner			
Snacks			
Snacks			
Snacks			

Circle which is most appropriate : I filled out the table based on

Typical routine **What I ate in the last 24 hours** **Both**

What is your heaviest meal?

When is bedtime?

How many cups of coffee or tea do you drink a day?

How many cans/servings of soda do you drink a day?

Circle all that apply

Large meals:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Late night meals:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Spicy foods:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Tomato based foods:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Citrus based foods:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Chocolate:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Caffeine:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Alcohol:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Soda:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me
Dairy products:	I try to avoid	Bother me	I never eat	Don’t bother me	Help me

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Swallowing Assessment

NAME: _____ DATE: _____

Do you take 100 % of your nutrition by mouth?

If not, what percent of the time can you swallow by mouth?

Please think about your symptom experiences and choose the best answer.

Over the **past 14 days**, on average, how often have you had the following? If your response falls between two categories, please make your best guess. If you are unable to eat the type of food in the question, please check "Cannot eat this."

X = Cannot eat this
0 = Rarely / Never
1 = Once or twice a month
2 = 1 – 2 times per week
3 = 3 – 5 times per week
4 = Daily or almost daily
5 = Several times per day

Trouble eating solid food (meat, bread, vegetables)
0 1 2 3 4 5 X

Trouble eating soft foods (yogurt, jello, pudding)
0 1 2 3 4 5 X

Trouble drinking liquids
0 1 2 3 4 5 X

Pain while Swallowing
0 1 2 3 4 5 X

Coughing or choking while swallowing food or liquids
0 1 2 3 4 5 X

Over the **past 14 days**, on average, how would you rate your discomfort or pain during swallowing? If you are unable to eat the type of food, please check "Cannot eat this."

X = Cannot eat this
0 = None
1 = Very Mild
2 = Mild
3 = Moderate
4 = Moderately Severe
5 = Severe

Pain or discomfort while eating solid food (meat, bread, vegetables)

0 1 2 3 4 5 X

Pain or discomfort eating soft foods (yogurt, jello, pudding)

0 1 2 3 4 5 X

Pain or discomfort drinking liquids

0 1 2 3 4 5 X

Approximately how many times in the **past 12 months** have you:

Had food stuck in your throat or esophagus for a period lasting longer than 30 minutes? _____
Had to visit the emergency room because of food stuck in your throat or esophagus? _____

In general, how often do you have trouble swallowing or does food get stuck?

None Occasionally Daily Each Meal

In general, how often do you have chest pain while or after eating?

None Occasionally Daily Each Meal

In general, how often do you feel fluid or food come up your chest after eating?

None Occasionally Daily Each Meal

Have you lost any weight over the past year? No Yes

If yes, how much? _____ pounds

GERD-Health Related Quality of Life Questionnaire (GERD-HRQL)

NAME: _____ DATE: _____

Please indicate if you are taking any of the Proton Pump Inhibitors (PPIs) listed below

□ omeprazole (Prilosec, Prilosec OTC, Zegerid)
□ lansoprazole (Prevacid)
□ pantoprazole (Protonix)
□ rabeprazole (Aciphex)
□ esomeprazole (Nexium)
□ dexlansoprazole (Dexilant)

□ Off PPIs If off, for how long? _____ days / months

*Please check the box to the right of each question which best describes your experience over the past **2 weeks.***

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

1.	How bad is the 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.	If you take medication, does this affect your daily life?	□0	□1	□2	□ 3	□4	□5
10.	How bad is the regurgitation?	□0	□1	□2	□ 3	□4	□5
11.	Regurgitation when lying down?	□0	□1	□2	□ 3	□4	□5
12.	Regurgitation when standing up?	□0	□1	□2	□ 3	□4	□5
13.	Regurgitation after meals?	□0	□1	□2	□ 3	□4	□5
14.	Does regurgitation change your diet?	□0	□1	□2	□ 3	□4	□5
15.	Does regurgitation wake you from sleep?	□0	□1	□2	□ 3	□4	□5

REFLUX SYMPTOM INDEX

*Within the **last month**, how did the following problems affect you? (0-5 rating scale with 0 = No problem and 5 = Severe)*

1.	Hoarseness or a problem with your voice	□0	□1	□2	□ 3	□4	□5
2.	Clearing your throat	□0	□1	□2	□ 3	□4	□5
3.	Excess throat mucous or postnasal drip	□0	□1	□2	□ 3	□4	□5
4.	Difficulty swallowing food, liquids or pills	□0	□1	□2	□ 3	□4	□5
5.	Coughing after you ate or after lying down	□0	□1	□2	□ 3	□4	□5
6.	Breathing difficulties or choking episodes	□0	□1	□2	□ 3	□4	□5
7.	Troublesome or annoying cough	□0	□1	□2	□ 3	□4	□5
8.	Sensations or something sticking in your throat	□0	□1	□2	□ 3	□4	□5
9.	Heart burn, chest pain, indigestion, or stomach acid coming up	□0	□1	□2	□ 3	□4	□5