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 thyroid trouble
- Diabetes
- Anemia (low blood count)
- Blood clot in lungs or legs
- Other blood disorders
- Poor Circulation
- Arthritis
- Stroke
- Seizures
- Depression or Anxiety
Have you ever had the following operations? (Please check all that apply)

- ☐ Removable gallbladder
- ☐ Fundoplication
- ☐ Antireflux surgery
- ☐ Hiatal hernia repair
- ☐ Gastric sleeve
- ☐ Gastric bypass
- ☐ Lap Band placement
- ☐ Myotomy for Achalasia
- ☐ Removal of stomach (part or all)
- ☐ Any other surgery on the esophagus or stomach

- ☐ Removal of appendix
- ☐ Hemorrhoid Surgery
- ☐ Removal of part/all of colon
- ☐ Removal of Spleen
- ☐ Heart Bypass
- ☐ Angioplasty
- ☐ Removal of Kidney
- ☐ Artificial blood vessel graft
- ☐ Replacement of Heart Valve

Please list any other medical conditions or operations:

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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
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.

<table>
<thead>
<tr>
<th></th>
<th>Typical timing</th>
<th>Typically what you eat</th>
<th>Check if not applicable</th>
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</thead>
<tbody>
<tr>
<td>Typical Breakfast</td>
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<tr>
<td>Typical Lunch</td>
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<tr>
<td>Typical Dinner</td>
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<td>Snacks</td>
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<tr>
<td>Snacks</td>
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</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Category</th>
<th>I try to avoid</th>
<th>Bother me</th>
<th>I never eat</th>
<th>Don't bother me</th>
<th>Help me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large meals</td>
<td></td>
<td></td>
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<tr>
<td>Late night meals</td>
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<tr>
<td>Spicy foods</td>
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<td>Tomato based foods</td>
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<td>Citrus based foods</td>
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<td>Chocolate</td>
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<tr>
<td>Caffeine</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Soda</td>
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<tr>
<td>Dairy products</td>
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</tbody>
</table>
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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble eating solid food (meat, bread, vegetables)</td>
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<td></td>
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<tr>
<td>Trouble eating soft foods (yogurt, jello, pudding)</td>
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<tr>
<td>Trouble drinking liquids</td>
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<tr>
<td>Pain while Swallowing</td>
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<tr>
<td>Coughing or choking while swallowing food or liquids</td>
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</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>X</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>X</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

Pain or discomfort drinking liquids

<table>
<thead>
<tr>
<th>X</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

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 Occasional Daily Each Meal

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

None Occasional Daily Each Meal

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

None Occasional 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