Heartburn, GERD, Hiatal Hernia Patients

(Please Print)

Name: _____

Email: _____

Date: _____

City of Residence: _____

Where did you hear about us? Please **circle** all that apply:

Physician's Website Hospital Website Facebook LINX Website Friend Family Member

Physician Referral (his/her name): _____ Other: _____

Please circle the number that best reflects your symptoms using the scoring scale provided below.

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 (if not taking medications)?	0	1	2	3	4	**5**
2. Heartburn when lying down (if not taking medications)?	0	1	2	3	4	**5**
3. Heartburn when standing up (if not taking medications)?	0	1	2	3	4	**5**
4. Heartburn after meals (if not taking medications)?	0	1	2	3	4	**5**
5. Does heartburn change your diet (if not taking medications)?	0	1	2	3	4	**5**
6. Does heartburn wake you from sleep (if not taking medications)?	0	1	2	3	4	**5**
7. Do you have difficulty swallowing (if not taking medications)?	0	1	2	3	4	**5**
8. Do you have bloating or gassy feelings (if not taking medications)?	0	1	2	3	4	**5**
9. Do you have pain with swallowing (if not taking medications)?	0	1	2	3	4	**5**
10. If you take medication, does this affect your daily life?	0	1	2	3	4	**5**
11. How satisfied are you with your present condition? (please circle)	Satisfied		Neutral		Dissatisfied	

Final score _____