

Bagshahi Bariatric and General Surgery

Patient Name: _____ DOB/Age: _____

Initial Visit _____ POST-OP _____ MO/YR

REFLUX/GERD QUESTIONNAIRE

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 daily activities

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|---|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. How bad is your heartburn? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 2. Heartburn when lying down? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 3. Heartburn when standing up? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 4. Heartburn after meals? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 5. Does heartburn change your diet? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 6. Does heartburn wake you from sleep? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 7. Do you have difficulty swallowing? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 8. Do you have pain with swallowing? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 9. Do you have bloating or gassy feelings? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 10. If you take medications, does this affect your daily life? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| 11. How satisfied are you with present condition? | <input type="checkbox"/> Satisfied <input type="checkbox"/> Neutral <input type="checkbox"/> Dissatisfied | | | | | |
| 12. Are you currently taking any medications for heartburn or GERD? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

Medications you have taken in the past or are currently taking:

Hossein Bagshahi, MD