GASTROESOPHAGEAL REFLUX DISEASE/HIATAL HERNIA

Patient name ____ Date ______________________

1. When were you diagnosed and by whom: ____

2. Please fill in the approximate dates and location of the test that are completed:

   Upper GI x-ray ____

   Barium Swallow ____

   Esophageal Manometry ____

   Upper GI Endoscopy ____

3. Do you ever have pain or heartburn: Yes_____ No _____

   Location & Radiation ____

   Character ____

   Onset & Duration ____

   Precitating & aggravating factors ____

   ____

   Alleviating factors ____

   Frequency of occurrence ____

4. Do you ever have a sour taste in your throat: Yes _____ No _____

   Frequency if yes ____

   Related to eating or sleeping ____

5. Do you ever have difficulty swallowing? Yes _____ No _____

   Frequency if yes ____

6. Do you sleep with your bed elevated or with several pillows? Yes _____ No _____

7. Do you practice a low fat diet? Yes _____ No _____

8. Do you minimize your food intake before bedtime? Yes _____ No _____

9. Do you minimize your alcohol/caffeine intake? Yes _____ No _____

10. What current heartburn medications are you taking? _______________________________________

11. Have you had any change in bowel habits? ____