

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### GERD-HRQL SCALE

0= No symptoms

1= Symptoms noticeable, but not bothersome

2= Symptoms noticeable and bothersome, but not every day

3= Symptoms bothersome everyday

4= Symptoms affect daily activities

5= Symptoms are incapacitating- unable to do daily activities

Please circle the correct response to the following questions:

- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1. How bad is your 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. Do you have gassy or bloating feelings?                  | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. If you take medication, does it affect your daily life? | 0 | 1 | 2 | 3 | 4 | 5 |

How satisfied are you with your present condition? Satisfied          Neutral          Dissatisfied