CLEAR

THE CENTERS FOR ADVANCED ENT CARE
15204 Omega Drive Suite 310
Rockville MD 20850

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Patient Name: _____ Date of Birth:_____

Referring Physician: _____

Do you have any of these symptoms?	Never	Daily	Several days a week	Monthly or less
Heartburn or indigestion?	☐	☐	☐	☐
Frequently clear your throat?	☐	☐	☐	☐
Chronic cough that has lasted more than a month?	☐	☐	☐	☐
Food seems to stick in your throat, difficult to swallow?	☐	☐	☐	☐
Sinuses blocked or causing post nasal drip?	☐	☐	☐	☐
Wake during the night?	☐	☐	☐	☐
Difficulty breathing?	☐	☐	☐	☐
Do you have Asthma? ☐ Yes ☐ No				
Any diagnosed lung disease? _____	☐	☐	☐	☐
Do you have allergies? Please describe:	☐	☐	☐	☐

Do you take any medications for acid reflux?

Medication _____ dose_____ last dose? _____

Are you willing to take a PPI (acid suppression medication) on a trial basis to see if it resolved your symptoms? ☐ Yes ☐ No

Do you prefer an evidence based test to determine the level of acid exposure and potential damage?
☐ Yes ☐ No

Lifestyle: (These are choices that can impact reflux)

Do you sleep with your head elevated? ☐ Yes ☐ No

Do you sleep with the windows open? ☐ Yes ☐ No

Do you eat within three hours of going to bed? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you need to lose weight? ☐ Yes ☐ No

I,_____ certify all information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____