|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: |   |   |   |   |

Patient Name: Date of Birth:

Referring Physician:

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: