PLEASE RETURN FORMS BY:
EMAIL: Cal.Bar@ahs.ca or FAX: (403) 955-8634 or MAIL: 1820 Richmond Rd SW, Calgary, AB, T2T 5C7

Date: ____________________

Name: ____________________
Date of birth: ____________________
Healthcare #: ____________________

	GERD-HRQL **Gastroesophageal Reflux Disease – Health Related Quality of Life Instrument**
	Scale: 0 = No Symptoms 1 = Symptoms noticeable, but not bothersome 2 = Symptoms noticeable and bothersome, but not everyday 3 = Symptoms bothersome everyday 4 = Symptoms affect daily activities 5 = Symptoms are incapacitating; unable to do daily activities

Questions:	**0**	**1**	**2**	**3**	**4**	**5**
1. How bad is your heartburn?						
2. Heartburn when lying down?						
3. Heartburn when standing up?						
4. Heartburn after meals?						
5. Does heartburn change your diet?						
6. Does heartburn wake you from sleep?						
7. Do you have difficulty swallowing?						
8. Do you have pain with swallowing?						
9. Do you have bloating or gassy feelings?						
10. If you take medication, does this affect your daily life?						

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

For office coding ____ + ____ + ____ + ____ + ____ + ____ + ____ = Total score _______

Developed September 2017 as adapted from reference: V. Velanovich. Diseases of the Esophagus (2007) 20, 130-134