Heartburn and Reflux Center Intake Form

Patient Name: ________________________________  DOB: ______________  Age: __________  □ Male  □ Female

Address: (City, State, Zip) _______________________________________________________________________________________

Phone Numbers: Home __________________________  Mobile __________________________  Other __________________________

Referral Source:  □ Website  □ Friend  □ Advertisement  □ Other __________________________

Primary Care Physician __________________________

GI Physician __________________________

Past Medical History

Current Medications

Allergies

Height: __________________________  Weight: __________________________  BMI: __________________________

Currently taking medication for reflux?  □ Yes  □ No

Medication in the past for reflux?  □ Yes  □ No

How long have you experienced GERD symptoms?  □ < 3 months  □ 1-2 years  □ ________ years

Symptoms

□ Burning in breastbone  □ Stomach contents in mouth (regurgitation)  □ Nausea

□ Pain in middle/upper stomach/throat  □ Has cardiac issue been ruled out  □ Trouble sleeping due to heartburn

□ Taking OTC meds in addition to prescription  □ Asthma/wheezing  □ Chronic cough

□ Laryngitis  □ Hoarseness  □ Voice change

□ Chronic sinusitis  □ Bloating/gas  □ Dysphagia (difficulty swallowing)

Experience heartburn when:  □ Lying down  □ Standing up  □ After meals

Does heartburn change your diet?  □ Yes  □ No

Does heartburn wake you from sleep?  □ Yes  □ No

Have you been diagnosed with GERD?  □ Yes/Date: ______________  □ No

TexasHealth.org/HEB
Please complete this 10-question GERD Health Related Quality of Life Questionnaire:

Scale: 0 = No Symptoms  
       1 = Symptoms noticeable, but not bothersome  
       2 = Symptoms noticeable and bothersome, but not every day  
       3 = Symptoms bothersome every day  
       4 = Symptoms affect daily activities  
       5 = Symptoms are incapacitating, unable to do daily activities

Questions: (circle one)

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 bloating or gassy feelings?  0  1  2  3  4  5
10. If you take medications, does this affect your daily life?  0  1  2  3  4  5

TOTAL Score (50 points max.) _______________

How satisfied are you with your current condition:  ❑ Satisfied  ❑ Neutral  ❑ Dissatisfied

Are you concerned with the warnings regarding long-term heartburn medication use?  ❑ Yes  ❑ No

Alarms Symptoms
❑ Diagnosed dysphagia  ❑ Odynophagia  ❑ Weight loss  ❑ Bleeding  ❑ Anemia

Barrett’s Esophagus Risk Factors
❑ > 50 y/o  ❑ Male  ❑ Reflux sx > 5 – 10 years  ❑ Obesity (BMI >30)

Would you like a consult or evaluation with:  ❑ Gastroenterologist  ❑ Surgeon  ❑ Unsure

Appointment scheduled? ________________________________

Records received?  ❑ Yes/When: ________________________________  ❑ No