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REFLUX SURGERY PROGRAM QUESTIONNAIRE

Name: _____ Date of Birth:_____

Address: _____

Phone Number: (Home)_____(Cell/Work)_____

PLEASE PROVIDE YOUR PRIMARY CARE PHYSICIAN'S INFORMATION:

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

PLEASE PROVIDE YOUR GASTROENTEROLOGIST'S INFORMATION:

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

PLEASE CIRCLE THE FOLLOWING IF YOU ARE CURRENTLY OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS:
Please Rate Severity 1-3
1= monthly or less 2= weekly 3= everyday

Heartburn	Regurgitation	Vomiting	Belching
Reflux	Nausea	Bloating	Diarrhea
Afraid to Eat	Dysphagia	Odontophagia	Abdominal Pain
Bile in Mouth	Gas/Flatulence	Difficulty Sleeping	Get Full Quick
Loss of Appetite			

HOW LONG HAVE YOU SUFFERED FROM REFLUX?

_____

WHAT WAS YOUR FIRST SYMPTOM(S)?

_____

WHAT WAS YOUR WORST SYMPTOM(S)? _____

DO THESE SYMPTOMS OCCUR WHILE ON MEDICATION? YES___ NO___

WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST? HAVE THEY CONTROLLED YOUR SYMPTOMS?

_____

_____

ARE YOU CURRENTLY OR HAVE YOU BEEN UNDER THE CARE OF ANOTHER PHYSICIAN FOR THIS? YES___ NO___ IF YES, PLEASE PROVIDE THAT INFORMATION:

_____

_____

HAVE YOU HAD ANY DIAGNOSTIC TESTING DONE FOR THESE CONDITIONS? YES___ NO___ PLEASE INDICATE BELOW IF YOU HAD THE TESTING AND IF SO WHERE IT WAS DONE:

- **UPPER ENDOSCOPY** _____
- **MANOMETRY** _____
- **MOTILITY** _____
- **24 HOUR PH TEST** _____
- **GASTRIC EMPTYING STUDY**_____

OTHER THAN THE SYMPTOMS ABOVE, HAVE YOU EXPERIENCED ANY OF THESE SECONDARY SYMPTOMS? PLEASE CIRCLE THE FOLLOWING IF YOU ARE CURRENTLY OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS:
Please Rate Severity 1-3
1= monthly or less 2= weekly 3= everyday

Chest Pain/Angina	Asthma	Wheezing	Hoarseness
Sore Throat	Difficulty Breathing	Coughing	Dental Erosion
Choking	Forced Vomiting		

DO THESE PROBLEMS EFFECT YOUR SLEEP? YES___NO___ IF YES, HOW SO?

_____

_____

ARE THESE SYMPTOMS ASSOCIATED WITH EATING? YES___NO___ IF YES DO SPECIFIC FOODS TRIGGER REFLUX?

_____

_____

HOW LONG AFTER A MEAL DO YOU EXPERIENCE THESE SYMPTOMS?

_____

WHAT DO YOU TAKE TO MAKE IT FEEL BETTER?

_____

_____

HAVE YOU TRIED PRESCRIPTION OR OVER THE COUNTER MEDICATION? YES___NO___IF YES, PLEASE INDICATE WHICH MEDICATION AND WHAT DOSAGE.

_____

_____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST:

HEART DISEASE: YES___ NO___IF YES, PLEASE CHECK WHAT YOU'VE HAD OR HAVE

- Chest Pain/Angina____
- Heart Attack, how many events _____
- Coronary Artery Disease____
- Coronary Heart Failure____
- Arrhythmia____
- Atrial Fibrillation____
- Pacemaker____
- Pulmonary Embolism (blood clot in lung)____
- High Blood Pressure____
- CVA (stroke)____

VENOUS INSUFFICIENCY (VARICOSE VEINS): YES____ NO____

THROMBOPHLEBITIS: YES____ NO____

BREATHING PROBLEMS: YES____ NO____YES___IF YES, PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU

- Asthma____
- Shortness of Breath____
- COPD____
- Emphysema____
- Other: _____

SLEEP PROBLEMS: YES____ NO____IF YES, PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU

- Sleep Apnea____
- Snoring____
- Other: _____

DIABETES: YES____ NO____ IF YES, HOW LONG: _____IF YES, PLEASE CHECK WHAT APPLIES TO YOU

- Diet Controlled____
- Medication Controlled____
- Insulin Dependent____
- Gestational Diabetes (pregnancy related) Thyroid Issues: Yes____ No____

THYROID ISSUES: YES___ NO____IF YES, PLEASE SPECIFY:

_____

ARTHRITIS: YES____ NO____ IF YES, PLEASE CHECK WHAT APPLIES TO YOU

- Osteoarthritis____
- Rheumatoid Arthritis____

GASTROINTESTINAL ISSUES: YES____ NO____ IF YES, PLEASE CHECK WHAT APPLIES TO YOU

- Hiatal Hernia____
- Ulcers____
- Gallstones____
- Pancreatitis____
- Infected Gallbladder____
- Fatty Liver____
- Hepatitis____

CANCER: YES____ NO____ IF YES, PLEASE SPECIFY
ARE YOU CURRENTLY RECEIVING TREATMENT OR IN REMISSION?
Current Medications (Please indicate dose and frequency of each medication):

_____

_____

_____

_____

ALLERGIES AND INTOLERANCES (Please indicate allergen and reaction):

_____

_____

_____

_____

SURGICAL HISTORY

PLEASE CHECK ALL THAT APPLY:

- C-Section ____
- Tonsillectomy ____
- Appendectomy ____
- Gallbladder Surgery ____
- Ventral Hernia Repair ____
- Umbilical Hernia Repair ____
- Carpal Tunnel Repair ____
- Orthopedic Surgery Repair ____
- Cosmetic Surgery ____
- Other: _____
- Other: _____
- Other: _____

SOCIAL HISTORY

MARITAL STATUS: SINGLE___MARRIED___DIVORCED___WIDOWED

DO YOU DRINK ALCOHOL? YES____ NO____

IF YES, HOW MANY DRINKS PER DAY/WEEK? ____

DO YOU SMOKE CIGARETTES? YES ____NO____

IF YES, HOW MANY PACKS PER DAY? ____

HOW MANY YEARS HAVE YOU SMOKED?____

IF YOU HAVE QUIT, HOW LONG AGO DID YOU STOP? ____

IF YOU HAVE QUIT, HOW MANY YEARS DID YOU SMOKE?

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

REVIEW OF SYSTEMS:

HEAD:

NECK:

HEART:

LUNGS:

GU:

GI:

ORTHO:

SKIN:

DIAGNOSTIC TESTING:

EGD

UGI MANOMETRY/MOTILITY 24 PH

GASTRIC EMPTYING STUDY

TREATMENT PLAN/NEXT STEPS: