

GERD Impact Scale (GIS)

DO YOU SUFFER FROM ANY OF THE SYMPTOMS BELOW?

Please complete the following questions by marking one response per question. Consider your symptoms over the past week. There are no right or wrong answers. Be sure to answer every question.

In the past week...

Daily

Often

Sometimes

Never

1. How often have you had the following symptoms:

a. Pain in your chest or behind the breastbone?

b. Burning sensation in your chest or behind the breastbone?

c. Regurgitation or acid taste in your mouth?

d. Pain or burning in your upper stomach?

e. Sore throat or hoarseness that is related to your heartburn or acid reflux?

2. How often have you had difficulty getting a good night's sleep because of your symptoms?

3. How often have your symptoms prevented you from eating or drinking any of the foods you like?

4. How frequently have your symptoms kept you from being fully productive in your job or daily activities?

5. How often do you take additional medication other than what the physician told you to take (such as Tums, Rolaids, Maalox)?