

Combined Patient Assessment - Hiatal

1. Please select your first and second most bothersome symptoms and indicate the duration of these symptoms.

Primary Symptom (choose one)	Secondary Symptom (choose one)
<input type="checkbox"/> Heartburn <input type="checkbox"/> Regurgitation <input type="checkbox"/> Difficulty <input type="checkbox"/> Swallowing <input type="checkbox"/> Chest Pain <input type="checkbox"/> Hoarseness <input type="checkbox"/> Cough <input type="checkbox"/> Other: _____ <input type="checkbox"/> None	<input type="checkbox"/> Heartburn <input type="checkbox"/> Regurgitation <input type="checkbox"/> Difficulty <input type="checkbox"/> Swallowing <input type="checkbox"/> Chest Pain <input type="checkbox"/> Hoarseness <input type="checkbox"/> Cough <input type="checkbox"/> Other: _____ <input type="checkbox"/> None
Duration of Symptom: _____ Months	Duration of Symptom: _____ Months

2. Can you belch or burp?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Can you vomit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do your symptoms impact your social activities?	<input type="checkbox"/> No <input type="checkbox"/> Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Daily
5. Do you take medications for	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If Yes, please list medications:</i>

6. Do you have any of the following symptoms?
 Please fill out these questions to the best of your ability by selecting your symptom and its frequency and severity. If you are unable to answer the question because you are either not on any medication or you do not know your symptoms off medication, please leave them blank.

Heartburn (burning sensation behind breastbone)

	FREQUENCY					SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Regurgitation (food, liquid, or acid coming back into your mouth)

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Difficulty swallowing solid foods

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Chest Pain

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Abdominal Pain

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Bloating (feeling of distention of the abdomen)

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Nausea (feeling of vomiting)

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Pain in the throat while swallowing

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Feeling of fullness in the back of your throat

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Hoarseness

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Food or liquid getting into your windpipe, particularly at night

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Wheezing

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Coughing

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Shortness of Breath

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Sore Throat

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

Diarrhea

FREQUENCY						SEVERITY										
	Never	Once/ month	Once/ week	Once/ day	Several/ Day	Never	Mild			Moderate				Severe		Worst
Off Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10
On Anti-Reflux Meds	0	1	2	3	4	0	1	2	3	4	5	6	7	8	9	10

7. Decision Regret Scale

Please think about the decision you made about abdominal surgery after talking to your health professional.

Please show how you feel about these statements by selecting a choice from **Strongly Agree** to **Strongly Disagree**.

<i>It was the right decision</i>	Strongly Agree 1	Agree 2	Neither Agree Nor Disagree 3	Disagree 4	Strongly Disagree 5
<i>I regret the choice that was made</i>	Strongly Agree 1	Agree 2	Neither Agree Nor Disagree 3	Disagree 4	Strongly Disagree 5
<i>I would go for the same choice if I had to do it over again</i>	Strongly Agree 1	Agree 2	Neither Agree Nor Disagree 3	Disagree 4	Strongly Disagree 5
<i>The choice did me a lot of harm</i>	Strongly Agree 1	Agree 2	Neither Agree Nor Disagree 3	Disagree 4	Strongly Disagree 5
<i>The decision was a wise one</i>	Strongly Agree 1	Agree 2	Neither Agree Nor Disagree 3	Disagree 4	Strongly Disagree 5

Decision Regret Scale © AM O'Connor 1996