GERD SYMPTOM QUESTIONNAIRE FOR INFANTS AGED 1 THROUGH 11 MONTHS (GSQ-I)

Relationship to Subject:

☐ Mother ☐ Step Mother ☐ Grandmother ☐ Guardian

☐ Father ☐ Step Father ☐ Grandfather ☐ Other, *specify* _____

SYMPTOMS	**QUESTION A** How many times did each symptom occur in the past 7 days? *(such as 0, 1, 2, 3, etc.)*	**QUESTION B** On a scale of 1 to 7 how severe was the symptom usually? **1 = Not at all severe** **7 = Most severe** *(leave question B blank if your answer to question A is "0")*
1. **VOMITING / REGURGITATION** Throwing up/ swallowing food or liquids that have come back up into the child's mouth.	☐☐ Times in the past 7 days *(Do not leave blank)*	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7
2. **IRRITABILITY / FUSSINESS** Episodes of crying during feeding or inconsolable.	☐☐ Times in the past 7 days *(Do not leave blank)*	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7
3. **REFUSAL TO FEED**	☐☐ Times in the past 7 days *(Do not leave blank)*	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7
4. **CHOKING / GAGGING**	☐☐ Times in the past 7 days *(Do not leave blank)*	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7
5. **ARCHING BACK**	☐☐ Times in the past 7 days *(Do not leave blank)*	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7

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6. **EPISODES OF HICCUPS**	⌊__⌋ Times in the past 7 days *(Do not leave blank)*	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7
7. **OTHER:** *specify symptom below*	⌊__⌋ Times in the past 7 days	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7
8. **OTHER:** *specify symptom below*	⌊__⌋ Times in the past 7 days	**Not at all Severe** ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Most Severe** 1 2 3 4 5 6 7