GERD Assessment of Symptoms in Pediatrics Questionnaire (GASP-Q)

Date completed (dd-MMM-yyyy): ___ - ___ - ___ Time completed (24 hour clock): ___ : ___

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")*
ABDOMINAL PAIN / BELLY PAIN *it hurts, aches or burns in the middle of your belly but not in your chest.*	___ Times in the past 7 days	Not at all severe 1 2 3 4 5 6 7 Most severe
CHEST PAIN / HEARTBURN *it hurts, aches or burns in the middle of your chest behind your breastbone but not in your belly.*	___ Times in the past 7 days	Not at all severe 1 2 3 4 5 6 7 Most severe
DIFFICULTY SWALLOWING *foods or liquids feel like they are getting stuck and you have to swallow many times or drink more liquids to "unstick" them.*	___ Times in the past 7 days	Not at all severe 1 2 3 4 5 6 7 Most severe
NAUSEA *feeling sick to your stomach or that you may throw-up.*	___ Times in the past 7 days	Not at all severe 1 2 3 4 5 6 7 Most severe
VOMITING / REGURGITATION *throwing up or having food come up into your mouth and swallowing it.*	___ Times in the past 7 days	Not at all severe 1 2 3 4 5 6 7 Most severe

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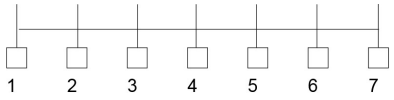
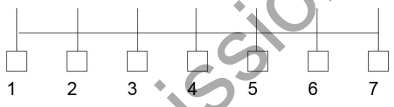
BURPING / BELCHING *air coming up from your stomach and out of your mouth.*	⌊⌋ Times in the past 7 days	Not at all severe  Most severe 1 2 3 4 5 6 7
CHOKING WHEN EATING *coughing when you are swallowing foods or liquids.*	⌊⌋ Times in the past 7 days	Not at all severe  Most severe 1 2 3 4 5 6 7
PAIN AFTER EATING *it hurts, aches or burns in the middle of your belly but not in your chest after you eat.*	⌊⌋ Times in the past 7 days	Not at all severe  Most severe 1 2 3 4 5 6 7