

Heartburn Symptom Record

You can complete the highlighted fields on this form online and then print the form for easy reference. Only text that is visible on the form is printed; scrolled text will not print. Any text you enter into these fields will be cleared when you close the form; you cannot save it.

| Record | Answer questions | Date: _____ Time: _____ | Date: _____ Time: _____ | Date: _____ Time: _____ |
|-------------------------------|---|----------------------------|----------------------------|----------------------------|
| Symptoms | <ul style="list-style-type: none"> • What were your symptoms? • How long did the heartburn last? • Do you have any other symptoms, such as asthma, hoarseness, or stomach pain? • Does pain radiate to another part of your body? | | | |
| Impact of symptoms | <ul style="list-style-type: none"> • Were you unable to sleep? • Were you unable to go to work? • Were you unable to perform your normal activities? | | | |
| Possible triggers of symptoms | <ul style="list-style-type: none"> • Are you taking any medicines? • Did exercise make your symptoms worse? • What did you eat? What did you drink? • Did you smoke before this episode? • Were you under stress? • Were you lying down or bending over during the episode? | | | |
| Treatment | <ul style="list-style-type: none"> • Did you take any medicines—over-the-counter or prescription—to relieve the heartburn? Record all treatments, including antacids, herbal remedies, and home remedies. | | | |
| Outcome of treatment | <ul style="list-style-type: none"> • Did the medicine provide complete relief? If yes, how long did the relief last? • Did your symptoms persist even though you took the medicine as indicated? | | | |