

Name: \_\_\_\_\_

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**EAR  
NOSE  
&  
THROAT** 

Otolaryngology  
Head & Neck Surgery  
Facial Plastic Surgery  
Allergy  
Sleep Apnea/Snoring

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Associates of Nassau County, PC

**REFLUX QUESTIONNAIRE**

Please respond yes/no to the following questions:

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|--|-----|----|
| 1. Do you suffer from chronic throat clearing?                     | Yes | No |
| 2. Do you have a troublesome or annoying cough?                    | Yes | No |
| 3. Do you notice hoarseness or changes in your voice?              | Yes | No |
| 4. Do you have excessive phlegm in your throat?                    | Yes | No |
| 5. Do you have a constant sensation of a lump in your throat?      | Yes | No |
| 6. Do you have post nasal drip?                                    | Yes | No |
| 7. Do you have difficulty swallowing food, pills or liquids?       | Yes | No |
| 8. Do you cough after you lie down?                                | Yes | No |
| 9. Do you have heartburn or indigestion even if only occasionally? | Yes | No |