Tolerability questionnaire

Study ID:                             Date:

Please rate degree of tolerance on a 0-10 pain scale.
(0 is none and 10 is severe)
(0 is good and 10 is not good)

How much pain did you experience during your procedure?   ________
Did you feel as if you were choking?     ________
Did you experience a gagging sensation during procedure?   ________
How much anxiety did you feel during the procedure?   ________
Overall how would you rate the procedure?    ________
Would you choose to have this procedure again to screen for
Barrett’s esophagus?                          (Yes/No) ________

Subject signature: _________________________