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: _____