Thank you for taking part in our National Health Survey.

On the next screen, you will see the consent form, and then we will ask you questions so that we can learn more about you and your health. The survey should take about 10 to 15 minutes.

Let's get started!

* Below is a list of gastrointestinal symptoms. Please select any symptom(s) that you have ever experienced in the past. Select all that apply.

- [ ] Abdominal or belly pain
- [ ] Difficulty swallowing (food or liquids sticking in your throat or chest, discomfort with swallowing, or choking sensation when swallowing)
- [ ] Bowel incontinence (have an accident or soil underclothes)
- [ ] Heartburn or acid reflux
- [ ] Bloating or swelling in your belly
- [ ] Diarrhea (loose, watery, or frequent stools)
- [ ] Constipation (hard, lumpy, or infrequent stools; straining)
- [ ] Nausea or vomiting
- [ ] I have not experienced any of these symptoms

* Has a healthcare provider ever diagnosed you with any of the following conditions? Select all that apply.

- [ ] Breast cancer
- [ ] Colorectal cancer
- [ ] Esophageal cancer
- [ ] Liver cancer
- [ ] Lung cancer
- [ ] Lymphoma
- [ ] Pancreatic cancer
- [ ] Stomach cancer
- [ ] Throat cancer
- [ ] I have not been diagnosed with any of these conditions

Congratulations, you qualified for our survey!

The questions on the next few pages will be about your difficulty swallowing (i.e., food or liquids sticking in your throat or chest, discomfort with swallowing, or choking sensation when swallowing). Click the Next button to continue.

You mentioned that you had previously experienced trouble swallowing. Approximately how long ago did you first start having difficulty swallowing?

	Year(s) ago	Month(s) ago
.		

* In the past 7 days, how often did food get stuck in your chest when you were eating?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did food get stuck in your throat when you were eating?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did you feel pain in your chest when swallowing food?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did you have difficulty swallowing solid foods like meat, chicken or raw vegetables, even after lots of chewing?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did you have difficulty swallowing soft foods like ice cream, apple sauce, or mashed potatoes?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did you have difficulty swallowing liquids?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did you have difficulty swallowing pills?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, in general, how severe was your difficulty swallowing?

- ◯ Not at all
- ◯ A little bit
- ◯ Somewhat
- ◯ Quite a bit
- ◯ Very much

* In the past 7 days, how often did you avoid eating certain foods to prevent trouble swallowing?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

* In the past 7 days, how often did you cut up your food into small pieces, or puree or blend your food to avoid trouble swallowing?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

* In the past 7 days, how often did it take you longer to finish eating your food when compared to other people at the table?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, how often did you need to drink water or some other liquid to help with trouble swallowing when eating food?

- Never
- Rarely
- Sometimes
- Often
- Always

* In the past 7 days, have you taken any oral medications?

- Yes
- No

* In the past 7 days, how often did you crush or cut your pills, or take liquid forms of medications to avoid trouble swallowing pills?

- ◯ Never
- ◯ Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

* In the past 7 days, have you had any pain with swallowing?

- Yes
- No

* Where 0 is no pain and 10 is the worst pain you could imagine, please rate how severe your pain with swallowing was over the past 7 days.

* Please respond to the following question by marking one box.

	1 (Not at all)	2	3	4	5 (Very much)
To what extent do you consider difficulty swallowing to be a severe health problem?	○	○	○	○	○

The next set of questions will be about any testing and treatments you may have gotten for your difficulty swallowing.

* Is there a place that you <u>usually</u> go to when you are sick or need advice about your health?

- ◯ Yes
- ◯ No
- ◯ I don't know

* What kind of place do you go to most often when you are sick or need advice about your health?

- Doctor's office, Kaiser, or other HMO
- Clinic, health center, or hospital clinic
- Emergency room
- No one place
- I don't know
- Other (please specify)

* Have you ever discussed your difficulty swallowing with a healthcare provider?

- Yes
- No
- I don't know

* With whom did you discuss your difficulty swallowing? Select all that apply.

- [ ] Primary care physician
- [ ] Gastroenterologist
- [ ] Ear, nose, and throat specialist
- [ ] Urgent care or emergency room physician
- [ ] Nurse practitioner or physician assistant
- [ ] Other healthcare provider (please specify)

* Have you had any of the following tests to evaluate your difficulty swallowing? Select all that apply.

- [ ] Upper endoscopy (your doctor puts a thin tube with a camera into your mouth and down into your esophagus and stomach)
- [ ] Barium video swallow (an xray test while you drink a chalky white liquid to examine your throat and upper esophagus)
- [ ] Barium esophagram (an xray test while you drink a chalky white liquid to examine your entire esophagus)
- [ ] Esophageal manometry (a flexible tube is passed through your nose and down into your esophagus, and you take ten sips of water)
- [ ] I have not had any of these tests
- [ ] I don't know
- [ ] Other (please specify)

* Have you ever needed a procedure to dilate, stretch out, or widen your esophagus?

- Yes
- No
- I don't know

* How many times have you needed a procedure to dilate, stretch out, or widen your esophagus?

- 1
- 2
- 3
- 4
- 5 to 10
- More than 10

* When was the last time you had a procedure done to dilate, stretch out, or widen your esophagus?

- Within the last 6 months
- 6 to 12 months ago
- 1 to 2 years ago
- 2 to 3 years ago
- More than 3 years ago

* Have you ever needed a procedure to remove food that was stuck in your esophagus?

- Yes
- No
- I don't know

* How many times have you needed a procedure to remove food that was stuck in your esophagus?

- 1
- 2
- 3
- 4
- 5 to 10
- More than 10

* When was the last time you had a procedure done to remove food that was stuck in your esophagus?

- ○ Within the last 6 months
- ○ 6 to 12 months ago
- ○ 1 to 2 years ago
- ○ 2 to 3 years ago
- ○ More than 3 years ago

* Have you ever been diagnosed by a healthcare provider with eosinophilic esophagitis (EoE)?

- Yes
- No
- I don't know

Approximately how long ago were you diagnosed with eosinophilic esophagitis?

	Year(s) ago	Month(s) ago
.		

* Which healthcare provider(s) have you seen for the evaluation and management of your eosinophilic esophagitis? Select all that apply.

- [ ] Primary care provider
- [ ] Gastroenterologist
- [ ] Allergist
- [ ] Dietician
- [ ] I don't know
- [ ] Other (please specify)

* Who is the healthcare provider who is most involved in treating your eosinophilic esophagitis?

- Primary care provider
- Gastroenterologist
- Allergist
- Dietician
- [Insert text from Other]

* Select all treatments that you are currently using for your eosinophilic esophagitis.

- ☐ Proton pump inhibitor (e.g., Aciphex, Dexilant, Nexium, Prevacid, Prilosec, Protonix, or Zegerid)
- ☐ Swallowed inhaled steroid (e.g., fluticasone, budesonide, or ciclesonide inhaler)
- ☐ Steroid liquid or suspension (e.g., budesonide mixed with a thickener such as Splenda)
- ☐ Steroid tablets (e.g., prednisone)
- ☐ Elimination diet (avoiding specific food groups such as milk, egg, soy, wheat, nuts, or shellfish based on allergy testing or a healthcare provider's recommendations)
- ☐ I am not currently taking any treatments for my eosinophilic esophagitis
- ☐ I don't know
- ☐ Other (please specify)

Please take some time to think about your level of satisfaction or dissatisfaction with your proton pump inhibitor for treating your eosinophilic esophagitis. We are interested in your evaluation of the effectiveness, side effects, and convenience of the medication *over the last two to three weeks.* For each question, please place a single check mark next to the response that most closely corresponds to your own experiences.

* How satisfied or dissatisfied are you with the ability of the proton pump inhibitor to prevent or treat your condition?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the way the proton pump inhibitor relieves your symptoms?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the amount of time it takes the proton pump inhibitor to start working?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat dissatisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How easy or difficult is it to use the proton pump inhibitor in its current form?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How easy or difficult is it to plan when you will use the proton pump inhibitor each time?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How convenient or inconvenient is it to take the proton pump inhibitor as instructed?

- ◯ Extremely inconvenient
- ◯ Very inconvenient
- ◯ Inconvenient
- ◯ Somewhat convenient
- ◯ Convenient
- ◯ Very convenient
- ◯ Extremely convenient

* Overall, how confident are you that taking this proton pump inhibitor is a good thing for you?

- ◯ Not at all confident
- ◯ A little confident
- ◯ Somewhat confident
- ◯ Very confident
- ◯ Extremely confident

* How certain are you that the good things about your proton pump inhibitor outweigh the bad things?

- ◯ Not at all certain
- ◯ A little certain
- ◯ Somewhat certain
- ◯ Very certain
- ◯ Extremely certain

* Taking all things into account, how satisfied or dissatisfied are you with this proton pump inhibitor?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

How long have you been taking your proton pump inhibitor?

	Year(s)	Month(s)
.		

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Please take some time to think about your level of satisfaction or dissatisfaction with your swallowed inhaled steroid (e.g., fluticasone, budesonide, or ciclesonide inhaler) for treating your eosinophilic esophagitis. We are interested in your evaluation of the effectiveness, side effects, and convenience of the medication *over the last two to three weeks*. For each question, please place a single check mark next to the response that most closely corresponds to your own experiences.

* How satisfied or dissatisfied are you with the ability of the swallowed inhaled steroid to prevent or treat your condition?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the way the swallowed inhaled steroid relieves your symptoms?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the amount of time it takes the swallowed inhaled steroid to start working?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How easy or difficult is it to use the swallowed inhaled steroid in its current form?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How easy or difficult is it to plan when you will use the swallowed inhaled steroid each time?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How convenient or inconvenient is it to take the swallowed inhaled steroid as instructed?

- Extremely inconvenient
- Very inconvenient
- Inconvenient
- Somewhat convenient
- Convenient
- Very convenient
- Extremely convenient

* Overall, how confident are you that taking this swallowed inhaled steroid is a good thing for you?

- Not at all confident
- A little confident
- Somewhat confident
- Very confident
- Extremely confident

* How certain are you that the good things about your swallowed inhaled steroid outweigh the bad things?

- Not at all certain
- A little certain
- Somewhat certain
- Very certain
- Extremely certain

* Taking all things into account, how satisfied or dissatisfied are you with this swallowed inhaled steroid?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

How long have you been taking your swallowed inhaled steroid?

	Year(s)	Month(s)
.		

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Please take some time to think about your level of satisfaction or dissatisfaction with your <u>steroid liquid or suspension (e.g., budesonide mixed with a thickener such as Splenda)</u> for treating your <u>eosinophilic esophagitis</u>. We are interested in your evaluation of the effectiveness, side effects, and convenience of the medication *over the last two to three weeks*. For each question, please place a single check mark next to the response that most closely corresponds to your own experiences.

* How satisfied or dissatisfied are you with the ability of the steroid liquid or suspension to prevent or treat your condition?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the way the steroid liquid or suspension relieves your symptoms?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the amount of time it takes the steroid liquid or suspension to start working?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How easy or difficult is it to use the steroid liquid or suspension in its current form?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How easy or difficult is it to plan when you will use the steroid liquid or suspension each time?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How convenient or inconvenient is it to take the steroid liquid or suspension as instructed?

- Extremely inconvenient
- Very inconvenient
- Inconvenient
- Somewhat convenient
- Convenient
- Very convenient
- Extremely convenient

* Overall, how confident are you that taking this steroid liquid or suspension is a good thing for you?

- Not at all confident
- A little confident
- Somewhat confident
- Very confident
- Extremely confident

* How certain are you that the good things about your steroid liquid or suspension outweigh the bad things?

- Not at all certain
- A little certain
- Somewhat certain
- Very certain
- Extremely certain

* Taking all things into account, how satisfied or dissatisfied are you with this steroid liquid or suspension?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

How long have you been taking your steroid liquid or suspension?

	Year(s)	Month(s)
.		

* Do you prepare your steroid liquid or suspension yourself or is it prepared for you at a compounding pharmacy?

- ◯ I prepare it myself
- ◯ It is prepared at a compounding pharmacy
- ◯ I don't know

* If you prepare your steroid liquid or suspension yourself, how convenient or inconvenient is it to prepare?

- ◯ Extremely inconvenient
- ◯ Very inconvenient
- ◯ Inconvenient
- ◯ Somewhat convenient
- ◯ Convenient
- ◯ Very convenient
- ◯ Extremely convenient
- ◯ Not applicable - I don't prepare it myself

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Please take some time to think about your level of satisfaction or dissatisfaction with your steroid tablets (e.g., prednisone) for treating your eosinophilic esophagitis. We are interested in your evaluation of the effectiveness, side effects, and convenience of the medication *over the last two to three weeks*. For each question, please place a single check mark next to the response that most closely corresponds to your own experiences.

* How satisfied or dissatisfied are you with the ability of the steroid tablets (e.g., prednisone) to prevent or treat your condition?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How satisfied or dissatisfied are you with the way the steroid tablets (e.g., prednisone) relieves your symptoms?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How satisfied or dissatisfied are you with the amount of time it takes the steroid tablets (e.g., prednisone) to start working?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How easy or difficult is it to use the steroid tablets (e.g., prednisone) in its current form?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How easy or difficult is it to plan when you will use the steroid tablets (e.g., prednisone) each time?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How convenient or inconvenient is it to take the steroid tablets (e.g., prednisone) as instructed?

- Extremely inconvenient
- Very inconvenient
- Inconvenient
- Somewhat convenient
- Convenient
- Very convenient
- Extremely convenient

* Overall, how confident are you that taking these steroid tablets (e.g., prednisone) is a good thing for you?

- Not at all confident
- A little confident
- Somewhat confident
- Very confident
- Extremely confident

* How certain are you that the good things about your steroid tablets (e.g., prednisone) outweigh the bad things?

- Not at all certain
- A little certain
- Somewhat certain
- Very certain
- Extremely certain

* Taking all things into account, how satisfied or dissatisfied are you with these steroid tablets (e.g., prednisone)?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

How long have you been taking your steroid tablets (e.g., prednisone)?

	Year(s)	Month(s)
.		

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Please take some time to think about your level of satisfaction or dissatisfaction with your elimination diet for treating your eosinophilic esophagitis. We are interested in your evaluation of the effectiveness, side effects, and convenience of the elimination diet *over the last two to three weeks*. For each question, please place a single check mark next to the response that most closely corresponds to your own experiences.

* How satisfied or dissatisfied are you with the ability of the elimination diet to prevent or treat your condition?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the way the elimination diet relieves your symptoms?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the amount of time it takes the elimination diet to start working?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

* How easy or difficult is it to avoid the specific food groups recommended by your healthcare provider?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How easy or difficult is it to plan an elimination diet meal each time?

- Extremely difficult
- Very difficult
- Difficult
- Somewhat easy
- Easy
- Very easy
- Extremely easy

* How convenient or inconvenient is it to follow the elimination diet as instructed?

- Extremely inconvenient
- Very inconvenient
- Inconvenient
- Somewhat convenient
- Convenient
- Very convenient
- Extremely convenient

* Overall, how confident are you that following the elimination diet is a good thing for you?

- Not at all confident
- A little confident
- Somewhat confident
- Very confident
- Extremely confident

* How certain are you that the good things about your elimination diet outweigh the bad things?

- Not at all certain
- A little certain
- Somewhat certain
- Very certain
- Extremely certain

* Taking all things into account, how satisfied or dissatisfied are you with this elimination diet?

- Extremely dissatisfied
- Very dissatisfied
- Dissatisfied
- Somewhat satisfied
- Satisfied
- Very satisfied
- Extremely satisfied

How long have you been following your elimination diet?

	Year(s)	Month(s)
.		

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* On average, how much money do you spend at the grocery store on food for your elimination diet?

- Less than $50
- $50 to $99
- $100 to $149
- $150 to $200
- More than $200
- I don't know

* Compared to your prior diet, are you spending more, less, or about the same amount of money on food for your elimination diet?

- More money
- Less money
- About the same amount of money
- I don't know

Please take some time to think about your level of satisfaction or dissatisfaction with your unlisted medication for treating your eosinophilic esophagitis. We are interested in your evaluation of the effectiveness, side effects, and convenience of the medication *over the last two to three weeks*. For each question, please place a single check mark next to the response that most closely corresponds to your own experiences.

* How satisfied or dissatisfied are you with the ability of the medication to prevent or treat your condition?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the way the medication relieves your symptoms?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How satisfied or dissatisfied are you with the amount of time it takes the medication to start working?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

* How easy or difficult is it to use the medication in its current form?

- ◯ Extremely difficult
- ◯ Very difficult
- ◯ Difficult
- ◯ Somewhat easy
- ◯ Easy
- ◯ Very easy
- ◯ Extremely easy

* How easy or difficult is it to plan when you will use the medication each time?

- ◯ Extremely difficult
- ◯ Very difficult
- ◯ Difficult
- ◯ Somewhat easy
- ◯ Easy
- ◯ Very easy
- ◯ Extremely easy

* How convenient or inconvenient is it to take the medication as instructed?

- ◯ Extremely inconvenient
- ◯ Very inconvenient
- ◯ Inconvenient
- ◯ Somewhat convenient
- ◯ Convenient
- ◯ Very convenient
- ◯ Extremely convenient

* Overall, how confident are you that taking this medication is a good thing for you?

- ◯ Not at all confident
- ◯ A little confident
- ◯ Somewhat confident
- ◯ Very confident
- ◯ Extremely confident

* How certain are you that the good things about your medication outweigh the bad things?

- ◯ Not at all certain
- ◯ A little certain
- ◯ Somewhat certain
- ◯ Very certain
- ◯ Extremely certain

* Taking all things into account, how satisfied or dissatisfied are you with this medication?

- ◯ Extremely dissatisfied
- ◯ Very dissatisfied
- ◯ Dissatisfied
- ◯ Somewhat satisfied
- ◯ Satisfied
- ◯ Very satisfied
- ◯ Extremely satisfied

How long have you been taking your unlisted medication?

	Year(s)	Month(s)
.		

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* Mark all treatments that you have used in the past and are not currently usingfor your esoinophilic esophagitis.

- [ ] I have not previously used these treatments for my eosinophilic esophagitis
- [ ] Proton pump inhibitor (e.g., Aciphex, Dexilant, Nexium, Prevacid, Prilosec, Protonix, or Zegerid)
- [ ] Swallowed inhaled steroid (e.g., fluticasone, budesonide, or ciclesonide inhaler)
- [ ] Steroid liquid or suspension (e.g., budesonide mixed with a thickener such as Splenda)
- [ ] Steroid tablets (e.g., prednisone)
- [ ] Elimination diet (avoiding specific food groups such as milk, egg, soy, wheat, nuts, or shellfish based on allergy testing or a healthcare provider's recommendations)
- [ ] Other (please specify)

We are almost done. The next set of questions will be about your general health and quality of life.

* Please respond to each item by marking one box per row.

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is:	○	○	○	○	○
In general, would you say your quality of life is:	○	○	○	○	○
In general, how would you rate your physical health?	○	○	○	○	○
In general, how would you rate your mental health, including your mood and your ability to think?	○	○	○	○	○
In general, how would you rate your satisfaction with your social activities and relationships?	○	○	○	○	○
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at school, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	○	○	○	○	○

* Please respond to the item by marking one box per row.

	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	○	○	○	○	○

* Please respond to the item by marking one box per row.

	Never	Rarely	Sometimes	Often	Always
In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	○	○	○	○	○

* Please respond to the item by marking one box per row.

	None	Mild	Moderate	Severe	Very severe
In the past 7 days, how would you rate your fatigue on average?	○	○	○	○	○

* Please respond to the item by marking one box per row.

	0 (No pain)	1	2	3	4	5	6	7	8	9	10 (Worst pain imaginable)
In the past 7 days, how would you rate your pain on average?	○	○	○	○	○	○	○	○	○	○	○

* Has a healthcare provider ever diagnosed you with any of the following conditions that affect the esophagus? Select all that apply.

- [ ] Achalasia
- [ ] Dermatomyositis
- [ ] Diffuse esophageal spasm
- [ ] Esophageal stricture
- [ ] Gastroesophageal reflux disease (GERD)
- [ ] Infection of the esophagus
- [ ] Jackhammer esophagus
- [ ] PPI-responsive esophageal eosinophilia
- [ ] Scleroderma
- [ ] I have not been diagnosed with any of these conditions
- [ ] Other (please specify)

* Has a healthcare provider ever diagnosed you with any of the following conditions that affect the gastrointestinal tract? Select all that apply.

- [ ] Celiac disease
- [ ] Cirrhosis
- [ ] Chronic constipation
- [ ] Crohn's disease
- [ ] Diabetes
- [ ] Fibromyalgia
- [ ] Gallstones
- [ ] HIV/AIDS
- [ ] Irritable bowel syndrome (IBS)
- [ ] Pancreatitis
- [ ] Peptic ulcer disease (stomach ulcer)
- [ ] Sjogren's syndrome
- [ ] Thyroid disease
- [ ] Ulcerative colitis
- [ ] I have not been diagnosed with any of these conditions

* Has a healthcare provider ever diagnosed you with any of the following neurologic conditions? Select all that apply.

- [ ] Stroke
- [ ] Parkinson's disease
- [ ] Myasthenia gravis
- [ ] Multiple sclerosis
- [ ] Spinal cord injury
- [ ] I have not been diagnosed with any of these conditions

* Has a healthcare provider ever diagnosed you with any of the following allergic conditions? Select all that apply.

- [ ] Asthma
- [ ] Chronic sinusitis
- [ ] Eczema or other skin allergy
- [ ] Seasonal or environmental allergy (i.e., allergic rhinitis)
- [ ] Food allergy
- [ ] I have not been diagnosed with any of these conditions
- [ ] Other (please specify)

The next page has our last set of questions, which will help us better understand your background.

* Please enter your age in years

[ ]

* What is your gender?

- ○ Male
- ○ Female

* How do you describe your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African-American
- ☐ Asian
- ☐ Other (please specify)

[ ]

* Are you of Spanish, Hispanic, or Latino origin?

- ○ Yes
- ○ No

* What is the highest level of education you have completed?

- ○ 8th grade or less
- ○ Some high school
- ○ Completed GED
- ○ High school graduate
- ○ Some college
- ○ College degree
- ○ Advanced graduate degree

* Are you now married, in a long-term relationship, widowed, divorced, separated, or never married?

- ◯ Married
- ◯ In a long-term relationship
- ◯ Widowed
- ◯ Divorced
- ◯ Separated
- ◯ Never married

* Which of the following categories best describes your employment status? Select all that apply.

- ☐ Homemaker
- ☐ Unemployed
- ☐ Retired
- ☐ On disability
- ☐ On leave of absence from work
- ☐ Full-time worker (40 or more hours per week)
- ☐ Part-time worker (less than 40 hours per week)
- ☐ Full-time student

* What is your best estimate of your household's total annual income

- ◯ Less than $10,000
- ◯ Between $10,000 to $20,000
- ◯ Between $20,001 to $50,000
- ◯ Between $50,001 to $100,000
- ◯ Between $100,001 to $200,000
- ◯ More than $200,000
- ◯ Prefer not to answer

* What type of health insurance do you have? Select all that apply.

- [ ] Insurance through a current or former employer or union
- [ ] Insurance purchased directly from an insurance company
- [ ] Medicare, for people 65 and older, or people with certain disabilities
- [ ] Medicaid, Medical Assistance, or any kind of government-assistance plan for this with low incomes or a disability
- [ ] TRICARE or other military health care
- [ ] VA (including those who have ever used or enrolled for VA health care)
- [ ] Indian Health Service
- [ ] I do not have health insurance
- [ ] Other (please specify)

* What state do you reside in?