**Intrinsic Erosion Questionnaire**

1. Do you have frequent heartburn? Yes No
2. If the answer to 1. is Yes, how frequent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you frequently snore? Yes No
4. Have you been diagnosed with sleep apnea? Yes No
5. Do you usually use multiple pillows for sleep? Yes No
6. Are you aware of grinding your teeth at night? Yes No
7. Has anyone told you that you grind your teeth? Yes No
8. Do you prefer sleeping on 1 side? Yes No
9. If you sleep on 1 side, which one? Right Left
10. Do you belch frequently? Yes No
11. Do you often have an acid taste in your mouth? Yes No
12. Do you vomit frequently? Yes No
13. Do you often have stomach aches? Yes No
14. Do you have gastric pain on awakening? Yes No
15. Do you experience voice change or hoarseness? Yes No
16. Do you have persistent coughing? Yes No
17. Do you clear your throat frequently? Yes No
18. Do you feel like you have a lump in your throat? Yes No
19. Do you often have a sore throat? Yes No
20. Do you have unexplained halitosis (bad breath)? Yes No
21. Do you have choking spells? Yes No
22. Do you have excess salivation? Yes No
23. Do you have post-nasal drip? Yes No