



PARTICIPANT ENTRY FORM

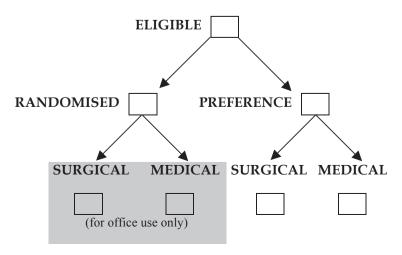
CONFIDENTIAL

This study is funded by the NIHR Health Technology Assessment Programme

ELIGIBILITY

Please mark relevant box as to whether participant has chosen to be randomised OR has declined and has opted for the preference arm.

Please put an X in the relevant boxes



PERSONAL INFORMATION

Instruction for completion:

if you make any errors while completing this form, please score through the incorrect data with a horizontal line and initial and date any changes

Please put an x in the relevant boxes

Title (Mr, Mrs etc)		Surname															
First Names																	
ADDRESS																	
House Name																	
House Number																	
Street Name																	
Town/City																	
County																	
Postcode																	
Telephone No (including code)																	
Maiden name (if female and ever married)																	
NHS Number (if know	vn)				ı	1		Hosp	oital	Nur	nber	(if k	nowr	1)			
CHI Number (if known - Scotland only)																	

DESCRIPTIVE INFORMATION ABOUT THE PARTICIPANT

Day Month Year											
Date of Birth / / /											
Sex Male Female											
Height m or	ft inches										
Weight kg or	st lbs										
1. Date of Recruitment Day Month Year											
	Yes No										
2. Does the participant take prescribed reflux medication	daily?										
3. When was the participant first prescribed medicine for their reflux symptoms?											
Month Year /											
4. Is the participant a current smoker?											
4. Is the participant a current smoker? Ye	s No Don't know										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the	s No Don't know										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the	s No Don't know participant first finished full										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the	s No Don't know e participant first finished full 16 years or less										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the time education?	s No Don't know participant first finished full 16 years or less 17-19 years old 20 years or over										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the	s No Don't know participant first finished full 16 years or less 17-19 years old 20 years or over										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the time education?	s No Don't know participant first finished full 16 years or less 17-19 years old 20 years or over e or part-time education?										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the time education?	s No Don't know participant first finished full 16 years or less 17-19 years old 20 years or over cor part-time education? Yes										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the time education? 7. Since leaving, have they undertaken any more full-time.	s No Don't know e participant first finished full 16 years or less 17-19 years old 20 years or over e or part-time education? Yes No										
4. Is the participant a current smoker? Ye 5. Does the participant suffer from asthma? 6. Please tick the box which accurately describes when the time education?	s No Don't know participant first finished full 16 years or less 17-19 years old 20 years or over cor part-time education? Yes										

Full time employment Part time employment Student Retired						Housework Seeking work Other										
GENERAL PRACTITIONER																
Initials	Surnam	e														
Practice Name																
Street Number]												
Street Name																
		Ī														
Town/City																
County																
Postcode																
Telephone No (including code)																
COLLABORATING CLINICIAN																
Title (Mr, Mrs, P	rofessor, I	Dr)	Sur	nam	e											
				I	<u> </u>	1	<u> </u>	1	1							
First Name(s) (if	known)															
Hospital																
Clinic name																

8. Please tick the box, which best describes the participant's current employment status.

Thank you for completing this information. Please return it in a reply-paid envelope to:
The REFLUX Trial Office, Health Services Research Unit (Flea),
University of Aberdeen, Foresterhill, ABERDEEN AB25 2ZD
Tel: 01224 000000 Fax: 01224 554580 E-mail: reflux@hsru.abdn.ac.uk