

STOMACH PAIN QUESTIONNAIRE

NAME: _____ **DATE:** _____

Please answer the following questions prior to your appointment and bring this questionnaire with you!

1. HOW LONG HAS THERE BEEN A PROBLEM?

2. WHERE IS PAIN LOCATED? DOES IT STAY IN ONE AREA OR MOVE AROUND? _____

3. HOW FREQUENT IS THE PAIN? (EX: Every day, every other day, 5 times a day, once a month, etc.) _____

4. WHAT DOES THE PAIN FEEL LIKE? (EX: stabbing, burning, cramping, ache, etc.) _____

5. HOW SEVERE IS THE PAIN? (ON A SCALE OF 0 to 10) _____. DOES IT INTERFERE WITH DAILY ACTIVITIES? _____

6. WHEN DOES PAIN OCCUR? IS THERE A CERTAIN TIME OF DAY WHEN IT IS MORE BOTHERSOME? _____

7. HOW LONG DOES THE PAIN LAST? (10 Seconds, 5 minutes, 3 hours) Please Describe. _____

8. DOES THE PAIN CAUSE WAKING FROM SLEEP? _____

9. IS THERE ANYTHING THAT CAUSES THE PAIN, OR MAKES IT WORSE? (EX: decreased sleep, stress, physical activity, excitement, menstrual period, etc.) _____

10. WHAT TREATMENT HAS BEEN TRIED FOR THE PAIN? _____
DOES IT HELP? _____
WHAT DOSE OF MEDICATION WAS GIVEN, IF ANY? _____
HOW LONG WAS THE MEDICATION USED? _____

11. IS THERE VOMITING OR THE FEELING OF WANTING TO THROW UP?
DESCRIBE. _____

12. IF MENSTRUATING, WHAT ARE PERIODS USUALLY LIKE? WHEN WAS THE
LAST PERIOD? HAS THERE BEEN ANY CHANGE IN PERIOD? ANY DISCHARGE?
(EX: how often, how many days, cramping, how many pads on the heaviest days?)

13. HAVE THERE BEEN IMPORTANT CHANGES OR STRESSES (TROUBLE IN
SCHOOL, PARENTS SEPARATING, WORRIES, A MOVE, THE LEAD IN A PLAY?)

14. DOES PAIN HAPPEN AS MUCH ON SCHOOL DAYS AS IT DOES ON WEEKENDS
OR HOLIDAYS?

15. IS THERE A FAMILY HISTORY OF INTESTINAL DISEASE? (EX: ulcers, polyps,
inflammatory bowel disease, irritable bowel syndrome).

16. HAVE THERE BEEN PROBLEMS WITH URINATION? (EX: Daytime accidents,
increased frequency or use of the bathroom, pain, bed-wetting, etc?)

17. HOW MUCH MILK IS DRUNK EACH DAY? IF FORMULA WAS USED DURING
INFANCY (WHICH ONE) _____ OR WAS BREAST MILK USED
FOR FEEDING IN INFANCY?

18. IS THERE FREQUENT BURPING? PASSING A LOT OF GAS?

19. WHAT ARE BOWEL MOVEMENTS LIKE? HOW OFTEN DO BOWEL MOVEMENTS OCCUR? HAS THERE BEEN A CHANGE IN ANY BOWEL MOVEMENTS?

20. WHAT COLOR IS THE STOOL?

21. HAVE THERE BEEN PROBLEMS WITH DIARRHEA? IF SO, HOW OFTEN?

22. DOES PAIN FEEL BETTER OR WORSE AFTER A BOWEL MOVEMENT?

23. DO YOU KNOW ANYONE ELSE WITH SIMILAR STOMACH PROBLEMS?

24. WHAT TYPE OF PETS ARE AROUND?

25. ATTEND OR WORK AT A DAYCARE FACILITY?

26. WHICH MEALS ARE EATEN DAILY? IS THE DIET HEALTHY? (Please Explain)

4-04

Thank you for answering these questions. Please remember to bring this questionnaire with you to your appointment.