

### Abdominal Pain Questionnaire

Please feel free to write in margin or on back if needed to better explain your pain

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

How long has the abdominal pain been present (indicate number)? \_\_\_ Day(s) \_\_\_ Hour(s)

Did the pain begin (please circle)? Suddenly-over a few minutes Gradually-over hours

Is the pain constant or is it intermittent (please circle)? Constant Intermittant

Describe the pain (circle all that apply): Sharp Burning Aching Dull Cramping

On a scale of 1 to 10, where 10 is excruciating pain, please assign a number to it: \_\_\_\_\_

Has pain similar to this (but maybe less severe) occurred in the past (circle)? Yes No

If yes, how often or how long ago? \_\_\_\_\_

If yes, circle or write in any chronic intestinal problem: Irritable Bowel Colitis

Is the pain located (please circle)? On the right side On the left side In the middle

Is the pain located (please circle)? Above the naval Below the navel At navel level

Does the pain radiate, or shoot anywhere (please circle)? Yes No

If yes, to where (please circle or write in) To the back To the leg To the chest

Does anything make the pain worse (please circle)? Yes No

If yes, what makes the pain worse? Movement Eating/Drinking \_\_\_\_\_  
If other Please fill in

Does anything make the pain better (please circle)? Yes No

If yes, what makes the pain better? Lying Still Not Eating \_\_\_\_\_  
If other Please fill in

Please list all prior abdominal surgery (Please circle all that apply or write in).

Appendix Gall bladder Hernia Females: Hysterectomy Tubal Ligation Ovaries

Are there any symptoms associated with the pain (circle all that apply or write in)?

Flu-like feeling Fever Weakness Jaundice Weight Loss

Are there any intestinal symptoms (please circle all that apply or write in)?

Loss of Appetite Nausea Vomiting Change in Bowel Movements

Are there any urinary symptoms associated with the pain (please circle all that apply)?

Burning with urination Change in urine color Frequency Kidney Stone History

Have tests been performed to evaluate the pain (please circle all that apply or write in)?

CAT Scan Ultrasound Colonoscopy Upper endoscopy(EGD) Blood Tests

For females only: Is it possible you could be pregnant? Yes No

What was the date of your last menstrual period? \_\_\_/\_\_\_/\_\_\_

Is there a history of endometriosis? Yes No