

Abdominal Pain Questionnaire

Name: _____

DOB: _____

1. When did the pain start?
2. How often do you get the pain? _____ daily _____ weekly
3. How long does the pain last?
4. What makes the pain worse?
5. What makes the pain better?
6. Do you wake up from sleep due to the pain?
7. Does eating make the pain worse, better or no change?
8. Describe the pain and rate it on a scale of 1 to 10 (with 10 being the worst pain ever).
9. Is it associated with dairy products or certain foods?
10. Do you have excess gas or bloating?
11. Do you have heartburn or a sour stomach sensation?
12. Have your stools changed? How often do you have bowel movements? Any change in urination?
13. Have you had any fever, rash or joint pain?
14. Have you had any nausea or vomiting?
15. What other symptoms have you had?
16. How has the pain changed since it started?
17. Is there anyone else in your household ill?
18. Is there a family history for abdominal or kidney problems?
19. Have you traveled recently or have you been drinking well water?
20. Is there anything that you are nervous or anxious about? Are there any stressors or changes in your family or at school?
21. If you are a female and menstruating, when was your last period?