CHRONIC ABDOMINAL PAIN QUESTIONS

Name:_____ Date:_____

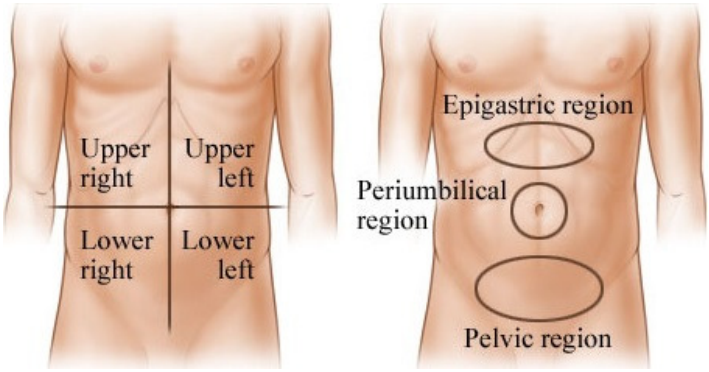
Date of Birth:_____

1. When did the pain start?

2. How often do you get the pain? _____daily _____weekly

3. How long does the pain last?

4. Where is the pain located? (mark on picture)



5. Do you wake up at night from the pain? Y N

6. Any weight loss? Y N

7. Have you had any blood in your stool? Y N

8. Are you taking any medications, antibiotics, vitamins, or herbal supplements?

9. Does eating make the pain better, worse, or no change?

10. Have you had any nausea or vomiting?

11. Have you had any diarrhea or constipation?

12. What makes the pain worse?

13. What makes the pain better?

14. Have you recently traveled outside the United States? Y N

15. Do you drink well water? Y N

16. Are there any stressors at home or at school?