IBS Questionnaire

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Today's Date______________________

Name ____

Symptoms that suggest IBS (check those that apply to you)

___Abdominal pain or discomfort

___Relief of the abdominal pain or discomfort with the passage of stool

___Onset of abdominal pain or discomfort associated with a change in stool frequency

___Onset of abdominal pain or discomfort associated with a change in form (appearance) of stool

___Passage of mucus during a bowel movement

___A feeling of abdominal fullness, swelling, or bloating

___A feeling the rectum is not empty after a bowel movement

___A sense of urgency associated with a bowel movement

___Less than three bowel movements a week

___More than three bowel movements a day

___A stool that is hard and difficult to pass

___Loose, unformed, or watery bowel movements

Symptoms that suggest a condition other than IBS (check those that apply to you)

___Onset of symptoms later in life (after age 45)

___Weight loss

___Fever

___Passage of blood in stool

___Awakening at night as the result of symptoms

___Family history of colon cancer, colon polyps, inflammatory bowel disorders,Celiac disease(gluten sensitivity)

The following questions are designed to help us diagnose IBS. Please circle YES or NO and provide additional information as needed.

1. How long have you had abdominal pain (i.e. months, years, weeks) ?

____

2. Do you have more than one pain? YES NO
If yes, how many different pains do you have?

____

____

3. Where is the worst pain?
___ Left lower abdomen ___ Left upper abdomen ___Right lower abdomen ___Right upper abdomen

4. How often does the pain occur, and how long does it generally last?

____

____

5. Does the pain ever awaken you from sleep? YES NO

6. Do you ever awaken from sleep because of diarrhea? YES NO

7. Is the pain ever so severe that it is unbearable and interferes with your normal daily activities? YES NO

8. On a scale of 1 (no pain) to 10 (unbearable pain), how would you rate your pain at its worst? _____

9. How would you describe the pain? ___Cramping ___Aching ___Burning ___Knifelike ___Other:

____

10. Have you found anything that you can do or take to alleviate the pain?

____

____

11. Does eating or drinking make the pain worse? YES NO

12. Have you identified certain foods that seem to trigger pain or diarrhea? YES NO
If so, please list those foods:

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____

____

13. Describe your typical pattern of bowel movements and the consistency of feces (i.e., one bowel movement every three days, which is hard and difficult to pass; or two or three loose, watery bowel movements a day)

____

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____

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14. How did your digestive symptoms develop? ___ Suddenly ___ Gradually

If sudden, describe the circumstances and symptoms at the time of initial onset:

____

____

15. Has this pattern remained constant, or has it changed in recent months?

____

____

16. Is the pain usually relieved after a bowel movement? YES NO

17. Do you have a change in the frequency or form (appearance) of bowel movement at the onset of pain? YES NO
If YES, check the following that applies at the onset of pain:
___ More loose ___ More frequent ___Less frequent ___More hard ___Difficult to pass

18. Do you have any of the following associated symptoms?
___ Bloating ___Belching ___Gas ___Nausea ___ Vomiting
Since your symptoms began, have you been passing more gas than before? YES NO

19. Have you passed mucus in your stool? YES NO

20. Have you lost weight in recent months? YES NO
If so, how much, over what period of time, and to what do you attribute the weight loss?

____

21. Have you passed blood in your stool, or had any black, tarry bowel movements? YES NO

22. Have you ever had fever associated with your symptoms? YES NO

23. Have you previously been evaluated for these complaints? YES NO
If so, what tests were performed, and what were the results?

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24. Comment on the effectiveness or side effects of any and all previously prescribed medications that you have taken for your complaints:

____

____

____

25. Have you ever been told you have IBS or spastic colon? YES NO

26. Do you often feel nervous or anxious? YES NO

27. Does stress make your IBS symptoms worse? YES NO

28. Do you often feel sad or depressed? YES NO

29. Are you currently receiving mental health care? YES NO

30. Have you ever received mental health care? YES NO

31. Are you satisfied with your current state of mental health? YES NO

32. Have you ever felt suicidal or self-destructive? YES NO

33. Do you have frequent dreams or recurrent nightmares? YES NO

34. Have you ever had a black-out or lost time? YES NO

35. Have you ever been the victim of physical or sexual abuse? YES NO

36. Do you ever become fearful or anxious when out in public? YES NO

37. Have you ever had headaches caused from various foods? YES NO
If yes, please list those foods:

____

____

____

38. Do you have any other medical problems you would consider uncontrolled at this time? YES NO
If yes, please list those problems:

____

____

____

39. Have you had your gallbladder removed?   YES   NO

40. Have you ever had, or been treated for, Giardia?   YES   NO

41. Do you have frequent pains in the neck, shoulders and/or back?   YES   NO

42. Describe your energy level:
___ Poor   ___Fair   ___Good   ___Excellent

43. Do you have cravings for certain foods?   YES   NO
If yes, please list those foods:

____

____

____

44. Do you regularly consume any of the following?
Check those that apply:
___ Fruit juices   ____Sodas   ___Diet sodas   ___Dietetic foods
___ Foods with artificial sweeteners   ___ Gum or mints   ___Carbonated beverages
___ Foods with MSG or "flavor enhancers"

For Female Patients Only

45. Are you pregnant, or do you think you might be?   YES   NO

46. Do your digestive symptoms worsen prior to the onset of your menstrual period?   YES   NO

47. Do you have pain with intercourse?   YES   NO