

# IBS Questionnaire

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Today's Date \_\_\_\_\_

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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) ?

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2. Do you have more than one pain? YES NO

If yes, how many different pains do you have?

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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?

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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:

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

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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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14. How did your digestive symptoms develop?  Suddenly  Gradually

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

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

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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?

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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:

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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:

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38. Do you have any other medical problems you would consider uncontrolled at this time? YES NO

If yes, please list those problems:

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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:

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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