IBS Questionnaire

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Today's Date _____
[MM/DD/YYYY]

Name: _____ **Date of Birth:** _____
[MM/DD/YYYY]

Symptoms that suggest irritable bowel syndrome (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 a result of symptoms

Family history of ☐ colon cancer ☐ colon polyps ☐ inflammatory bowel disorder

☐ Celiac disease ☐ gluten sensitivity

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

1. How long have you had abdominal pain? _____
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? Choose one from list Select one or describe below.

_____

4. How often does the pain occur? _____
5. How long does it generally last? _____
6. Does the pain ever awaken you from sleep? ○ YES ○ NO
7. Do you ever awaken from sleep because of diarrhea? ○ YES ○ NO
8. Is the pain ever so severe that it is unbearable and interferes with your normal daily activities?
   ○ YES ○ NO
9. On a scale of 1 (no pain) to 10 (unbearable), how would you rate your pain at its worst? ☐
10. How would you describe the pain? Select One

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

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12. Does eating or drinking make the pain worse? ○ YES ○ NO
13. Have you identified certain foods that seem to trigger pain or diarrhea? ○ YES ○ NO
    If yes, please list those foods: _____

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14. 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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15. How did your digestive symptoms develop? ○ Suddenly ○ Gradually
    If suddenly, describe the circumstances and symptoms at the time of initial onset:

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16. Has this pattern remained constant, or has it changed in recent months? Describe below

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17. Is the pain usually relieved after a bowel movement? ○ YES ○ NO
18. Do you have a change in the frequency or form of bowel movement at the onset of pain?
    ○ YES ○ NO If YES, check the following that applies at the onset of pain:
    ☐ More frequent ☐ Less frequent
    ☐ More loose ☐ More hard ☐ Difficult to pass
19. Do you have any of the following associated symptoms: (check all that apply)
    ☐ Bloating ☐ Belching ☐ Gas ☐ Nausea ☐ Vomiting
20. Since your symptoms began, have you been passing more gas than before? ○ YES ○ NO
21. Have you passed mucus in your stool? ○ YES ○ NO
22. Have you lost weight in recent months? ○ YES ○ NO
    If YES, how much, over what period of time and to what do you attribute the weight loss to?

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23. Have you passed blood in your stool or had any black, tarry bowel movements? ○ YES ○ NO
24. Have you ever had fever associated with your symptoms? ○ YES ○ NO

25. Have you previously been evaluated for these complaints? ○ YES ○ NO

If YES, what tests were performed, and what were the results?

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26. 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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27. Have you ever been told you have IBS or spastic colon? ○ YES ○ NO
28. Do you often feel nervous or anxious? ○ YES ○ NO
29. Does stress make your IBS symptoms worse? ○ YES ○ NO
30. Do you often feel sad or depressed? ○ YES ○ NO
31. Are you currently receiving mental health care? ○ YES ○ NO
32. Have you ever received mental health care? ○ YES ○ NO
33. Are you satisfied with your current state of mental health? ○ YES ○ NO
34. Have you ever felt suicidal or self-destructive? ○ YES ○ NO
35. Do you have frequent dreams or recurrent nightmares? ○ YES ○ NO
36. Have you ever had a black-out or lost time? ○ YES ○ NO
37. Have you ever been the victim of physical or sexual abuse? ○ YES ○ NO
38. Do you ever become fearful or anxious when out in public? ○ YES ○ NO
39. Have you ever had headaches caused from various foods? ○ YES ○ NO

If YES, please list those foods:

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40. Do you have any other medical problems you would consider uncontrolled at this time?

If YES, please list those problems:

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41. Have you had your gall bladder removed? ○ YES ○ NO
42. Have you ever had, or been treated for, Giardia? ○ YES ○ NO
43. Do you have frequent pain in the neck, shoulders and/or back? ○ YES ○ NO
44. Describe your energy level? _____
45. Do you have cravings for certain foods? ○ YES ○ NO
46. Do you regularly consume any of the following? Check those that apply:

- ☐ Fruit juices
- ☐ Foods with MSG or "flavor enhancers"
- ☐ Gum or mints
- ☐ Carbonated beverages
- ☐ Foods with artificial sweeteners
- ☐ Sodas
- ☐ Diet soda
- ☐ Dietetic Foods

For Female Patients Only

47. Are you pregnant, or do you think you might be? ○ YES ○ NO
48. Do your digestive symptoms worsen prior to the onset of your menstrual period? ○ YES ○ NO
49. Do you have pain with intercourse? ○ YES ○ NO