HEALTH SCIENCE RESEARCH 7505 FANNIN ST, Ste 210, Houston, TX 77054 713-790-9191
FAX 713-790-9292 www.HealthScienceResearch.com

GI QUESTIONNAIRE

NAME ____ **DATE** ____________________

1. I have been diagnosed with or told I might have:

Ulcerative Colitis ____ Ulcers ____ Gastritis ____
Crohn's Disease ____ Hiatus Hernia ____ Spastic or Irritable Colon ____
Diverticulosis ____ Colitis ____ Excess Acidity ____
Diverticulitis ____ H. Pylori ____ Parasites ____
Candida ____ Malabsorption _____ GERD (heartburn) _____
Gallbladder stones ______ Gallbladder surgery ____ Other _______________________

Date first began: _________________ Have you had a hysterectomy? Yes ___ No ___Were ovaries removed ? Y ___ No___

2. Particular foods bother my stomach or intestines. Yes ____ No ____

Which foods? ________________, _________________, ________________, ________________, _________________.

3. Which of these do you experience (check all that apply)

	Occasionally	Once every 2 weeks	Once a week	Several times a week	Daily	Severe/ always
Bloating						
Belching						
Heartburn						
Nausea						
Loss of appetite						
Abdominal pain						
Vomiting						
Loose stool						
Diarrhea						
Smelly stool						
Light, clay colored, or greasy stool						
Bright blood in stool						
Feeling of incomplete evacuation of stool						
Dark, tarry stool						

If you have abdominal pain:

- Where does the pain begin? ____________________________________ Where does the pain go or radiate? ________
____
- Does it vary according to your position? Yes ____ No ____ Which is best? ______________________________
- Does it vary with exercise? Yes ____ No ____ Does it get better or worse? Better ____ Worse _____
- Does it vary with emotional stress? Yes ____ No ____ Describe _______________________________________
- Does it get worse after eating? Yes ____ No ____ How long after your eat? ______________ minutes
- Is the pain lancinating like lightening or an electric shock? Yes ____ No _____ or,
- Is it strong and dull? Yes ____ No ____ Is it a burning or searing pain? Yes ____ No _____

4. Have you ever had hepatitis? Yes ____ No ____

If so, what type? Hepatitis A _____ B _____ C _____ Combined _______ Other ____________________

5. Have you ever had abdominal surgery? Yes ____ No ____

GO ON TO NEXT PAGE (OR OVER)

If so, what type? ____ When was it done? ___________________

What hospital? ____ Where ?___________________________________

6. Have you ever been jaundiced (yellow eyes, skin, dark urine)? Yes ____ No ____

7. Please list the prescribed drugs you have been given or took/take.

a. ____ f. ____
b. ____ g. ____
c. ____ h. ____
d. ____ i. ____
e. ____ j. ____

8. I have taken these supplements/OTC at one time or another. (Check all that apply.)

Probiotics ____ GI Formula ____ Fiber ______
Antispasmotics ____ Enzymes ____
Licorice _____ Antacids ____ Other __________________________
Sulfa Drugs ____ Steroids (Prednisone) ____

9. I have lost/gained (circle which) weight recently without trying to do so. Yes ____ No ____.

It has been ______ lbs in the last ______ weeks.

10. I have had xrays, scans, or ultrasounds of the abdomen/intestine/liver in the past Yes ____ No ____

If so, please describe.

Test done ____ When __________________ Where____________________
Test done ____ When __________________ Where ___________________
Test done ____ When __________________ Where ___________________

Ultrasound of abdomen or pelvis ________________________ When __________________ Where ___________________
CT scan of abdomen or pelvis _________________________ When __________________ Where ___________________
Colonoscopy____When __________________ Where ___________________

Upper endoscopy (EGD)_______________________________When___________________Where ___________________

Capsule endoscopy___________________________________ When __________________ Where ___________________

Occult blood in stool ____ How many samples done? __________ When __________ Where ______________________

Biopsy_____________________of What_________________When____________________Where ___________________

Biopsy_____________________of What_________________When____________________Where ___________________

11. Have you ever had a CDSA (Comprehensive Diagnostic Stool Analysis) test done? Yes ____ No ____

If yes, when ___________________where________________________________ Results __________________________

12. Did you ever have tests for intestinal parasites? Yes ____ No ____

If yes, when ___________________where ________________________________Results __________________________

13. Have you ever had tests for malabsorption or celiac disease?

If yes, when ___________________where ________________________________Results _________________________

14. Have you ever had food allergy tests done? Yes ____ No ____ If yes, when _________________________

Where __________________________ To what foods are were you allergic? ___________________(continue other side)

_________________________, ___________________________, ____________________________, ____________________

If you eliminated these foods, did it eliminate your symptoms or help in any way? Yes ___ No ___

15. Please describe anything not mentioned above which you feel is important.

____

____

____

____

____

____