

ABDOMINAL PAIN/ FLANK PAIN QUESTIONNAIRE

Patient Name:	Today's Date:
DOB:	Age:

Office Use:

Where is your pain located?
Date of injury ~or~ When did your pain start / /
How did your pain problem start?

Please mark "YES" or "NO" for each of the following conditions:	
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had any prior surgery for this or similar type pain problem? If yes, when? / /
<input type="checkbox"/> Y <input type="checkbox"/> N	UPPER abdominal pain
<input type="checkbox"/> Y <input type="checkbox"/> N	MID abdominal pain
<input type="checkbox"/> Y <input type="checkbox"/> N	LOWER abdominal pain
<input type="checkbox"/> Y <input type="checkbox"/> N	GROIN pain
<input type="checkbox"/> Y <input type="checkbox"/> N	FLANK (side or lower ribcage) pain
<input type="checkbox"/> Y <input type="checkbox"/> N	NAUSEA
<input type="checkbox"/> Y <input type="checkbox"/> N	VOMITTING
<input type="checkbox"/> Y <input type="checkbox"/> N	DIARRHEA
<input type="checkbox"/> Y <input type="checkbox"/> N	CONSTIPATION ~ Please list the date of your last bowel movement / /
<input type="checkbox"/> Y <input type="checkbox"/> N	BLOOD in your stool
<input type="checkbox"/> Y <input type="checkbox"/> N	HEMORRHOID history
<input type="checkbox"/> Y <input type="checkbox"/> N	GASTRIC ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N	DUODENAL ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N	HIATAL (or esophageal or diaphragmatic) hernia
<input type="checkbox"/> Y <input type="checkbox"/> N	REFLUX
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your pain worse when LYING down?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do ANTACIDS help your pain?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of Barrett's Esophagus
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your pain worse after EATING?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you still have your GALLBLADDER?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of KIDNEY STONES?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of PANCREATITIS?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of PORPHYRIA?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of DIVERTICULOSIS or DIVERTICULITIS?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of CROHN'S?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of ULCERATIVE COLITIS?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is pain relieved by a BOWEL MOVEMENT?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have URGENCY with bowel movement?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do DAIRY products increase your pain?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of LUPUS or POLYARTERITIS NODOSA?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of DEPRESSION?
<input type="checkbox"/> Y <input type="checkbox"/> N	History of ANXIETY or PANIC ATTACKS?

Office Use: