DuPage Medical Group Pediatrics

SCREENING QUESTIONNAIRE FOR RECURRENT ABDOMINAL PAIN

PATIENT'S NAME ____________________ DATE OF BIRTH ____________

1. How long has the pain been present? ____________________
2. How frequently does it occur? __________ (daily, sporadically) __________
3. How long does it last? __________ (minutes, hours)
4. Does it occur at specific times of the day? ____________________
5. Does it coincide with meals - either before, during or after? ____________________
6. Are the symptoms getting worse? More frequent? ____________________

   More severe? ____________________
7. Are there any associated symptoms? (Nausea, vomiting, fever, weight loss, loss of appetite, diarrhea, blood in the stool, headaches, joint pain or swelling, other?) ____________________
8. How would you describe the pain? _____ dull _____ stabbing

   _____ sharp _____ cramping
9. How severe is the pain on a scale of 1 - 10?
   Please circle:
   MILD 1 2 3 4 5 6 7 8 9 10 SEVERE
10. Where is the pain located? (check all that apply)

    _____ above belly button _____ right side
    _____ around belly button _____ left side
    _____ below belly button _____ moves around
11. What makes the pain worse? ____________________
12. What makes the pain better? ____________________
13. Have you used any over the counter medications & did they help? ____________________
14. How frequently does your child have a bowel movement? ____________________

    Has this changed recently? ____________________

    Does your child soil his/her underwear? ____________________

15. Is your child a picky eater? ______________________

16. Does he/she eat 5 - 6 servings of fruits & vegetables a day? ______________________

17. How many ounces of milk per day? ______________________

18. Is your child missing favorite activities because of the pain? ______________________

19. Has your child missed school because of the pain? ______________________

20. Are there any recent stressful events in your child's life? ______________________

21. Is there a family history of: Ulcers, GERD, IBS, Celiac Crohns, Colitis, Kidney Stones, Other? If yes, who. ______________________

22. Do you have any additional comments?

____

____

____

____

SIGNATURE ______________________________ DATE ______________

Parent/Guardian