Gastrointestinal Questionnaire

Name **Date**

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints. Leave the question blank if it does not apply to you.
0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

PART 1: Digestive Function

Section A:

1	Abdomen bloats after eating	0 1 2 3
2	Loss of taste for meat	0 1 2 3
3	Excessive upper or lower abdominal gas 1-3 hours after eating	0 1 2 3
4	Belching or burping after meals	0 1 2 3
5	Frequent upset stomach	0 1 2 3
6	Experience food allergies	0 1 2 3
7	Fasting affects your stomach	0 1 2 3
8	Coated tongue	0 1 2 3
9	Frequent constipation and/or diarrhea	0 1 2 3
10	Gas immediately following eating	0 1 2 3
11	Frequent heartburn	0 1 2 3
12	Vomiting of undigested food	0 1 2 3
13	Indigestion 1-3 hours after eating	0 1 2 3
14	Bad breath	0 1 2 3
15	Treated for anemia many times without success (Press 0 for NO, 1 for YES)	NO YES

Section B:

1	Chronic burning sensation in the stomach	0 1 2 3
2	Stomach pains just before meals	0 1 2 3
3	Stomach pains relieved by drinking milk/cream	0 1 2 3
4	Take antacids frequently	0 1 2 3
5	Stomach complaints aggravated by worry or tension	0 1 2 3
6	Frequent meals relieve your stomach pains	0 1 2 3
7	Experience sudden, acute indigestion	0 1 2 3
8	Acute stomach pain after eating or lying down	0 1 2 3
9	Spicy food or caffeine causes diarrhea	0 1 2 3
10	Excessive use of aspirin and other anti-inflammatory medications (including steroids)	0 1 2 3
11	Diagnosed with an ulcer (Press 0 for NO, 1 for YES)	NO YES
12	Pains subside when vacationing or relaxed (Press 0 for NO, 1 for YES)	NO YES
13	History of gastritis or ulcers (Press 0 for NO, 1 for YES)	NO YES
14	Stool is black when you are not taking an iron supplement (Press 0 for NO, 1 for YES)	NO YES

Section C:

1	Lower bowel gas several hours after eating	0 1 2 3
2	Bloating after meals	0 1 2 3
3	Stools are shiny and/or poorly formed	0 1 2 3
4	Difficult to gain weight	0 1 2 3
5	Skin is dry and flaky	0 1 2 3
6	Experience diarrhea frequently	0 1 2 3
7	Fiber irritates your diarrhea	0 1 2 3
8	Alternate between diarrhea/constipation	0 1 2 3
9	Experience food allergies	0 1 2 3
10	Frequent stomach cramps	0 1 2 3
11	Mucous in your stools	0 1 2 3
12	Pain on inside of left shoulder blade	0 1 2 3
13	Pain on left side of abdomen (lower rib cage)	0 1 2 3
14	Pass large amounts of foul-smelling stool	0 1 2 3
15	Fibrous foods and roughage cause constipation	0 1 2 3
16	Problems with acne	0 1 2 3
17	Low self-esteem	0 1 2 3
18	Hair is brittle and dry	0 1 2 3

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Section D:

1	Chemical sensitivities	0 1 2 3
2	Exposure to toxic chemicals/drugs/alcohol	0 1 2 3
3	Fatigue	0 1 2 3
4	Frequent belching/burping	0 1 2 3
5	Yellow in the whites of your eyes	0 1 2 3
6	Constipation	0 1 2 3
7	Abdominal cramps	0 1 2 3
8	Stools are light-colored and foul smelling	0 1 2 3
9	Consistent bloating and gas	0 1 2 3
10	Bad breath (halitosis) and/or body odor	0 1 2 3
11	Eye problems	0 1 2 3
12	Dry skin or hair	0 1 2 3
13	Bitter, metallic taste in mouth in mornings	0 1 2 3
14	Painful bowel movements	0 1 2 3
15	Skin on your feet peels	0 1 2 3
16	Pain at right shoulder blade	0 1 2 3
17	Pain radiates down outside of your legs	0 1 2 3
18	Pain on the right side of your abdomen	0 1 2 3
19	Frequent bad dreams/nightmares	0 1 2 3
20	Fatty foods cause nausea and distress	0 1 2 3
21	Chronic anger, frustration and/or irritability	0 1 2 3
22	Wake regularly between 1 and 3 a.m.	0 1 2 3
23	Bruise easily	0 1 2 3
24	Triglyceride level above 115 (Press 0 for NO, 1 for YES)	NO YES
25	Cholesterol level above 200 (Press 0 for NO, 1 for YES)	NO YES
26	High LDL - Low HDL cholesterol (Press 0 for NO, 1 for YES)	NO YES
27	Diagnosed with hepatitis/jaundice (Press 0 for NO, 1 for YES)	NO YES
28	History of gallbladder attacks or gallstones (Press 0 for NO, 1 for YES)	NO YES

PART 2: Eliminative Function

Section A:

1	Frequent diarrhea with no apparent cause	0 1 2 3
2	Bowel movements thin and pencil-like	0 1 2 3
3	Painful bowel movements	0 1 2 3
4	Alternating constipation/diarrhea	0 1 2 3
5	Blood in your stool	0 1 2 3
6	Mucous in your stool	0 1 2 3
7	Lower abdominal pain and tenderness	0 1 2 3
8	Excess gas and flatulence	0 1 2 3
9	Suffer from anxiety or depression	0 1 2 3
10	Raw fruits and vegetables cause intestinal pain	0 1 2 3
11	More than three bowel movements daily	0 1 2 3
12	Mood swings/irritability	0 1 2 3
13	Abdominal pain relieved by bowel movement or passing gas	0 1 2 3
14	History of constipation	0 1 2 3
15	History of antibiotic use (Press 0 for NO, 1 for YES)	NO YES
16	History of vaginal yeast infections (Press 0 for NO, 1 for YES)	NO YES
17	Frequently sick with a cold or infection (Press 0 for NO, 1 for YES)	NO YES

Section B:

1	Do you have itching, burning pain and/or inflammation in the rectal area?	0 1 2 3
2	Do you have bright red blood on the tissue paper after a bowel movement?	0 1 2 3
3	Do you have hemorrhoids? (Press 0 for NO, 1 for YES)	NO YES