Gastrointestinal Symptom Questionnaire

Name:

Date:

Please circle your response to the questions below. Use the following scale to grade your symptoms:

0 No problem

1 Problem of mild intensity (<3/10) and/or frequency (< 50% of the time)

2 Problem of moderate intensity (3-6/10) and/or frequency (50-75% of the time)

3 Problem of severe intensity (>7/10) and/or frequency (>75% of the time)

Symptom	**Score**			
Pain in upper abdomen (above navel)?	0	1	2	3
Is this pain relieved with food or acid blockers?	0	1	2	3
Is this pain worse with greasy food?	0	1	2	3
Pain in lower abdomen (below navel)?	0	1	2	3
Is this pain relieved with passing gas or stool?	0	1	2	3
Does this pain wake you up at night?	0	1	2	3
Heartburn?	0	1	2	3
Acid fluid or sour taste in the chest/throat?	0	1	2	3
Difficulty swallowing?	0	1	2	3
Does it hurt when you swallow?	0	1	2	3
Do you feel bloated after meals?	0	1	2	3
Do you feel sick after meals?	0	1	2	3
Do you vomit after meals?	0	1	2	3
Belching?	0	1	2	3
Do you have hard, infrequent stools?	0	1	2	3
Do you have loose, frequent stools?	0	1	2	3
Urgency to rush to the toilet?	0	1	2	3
Straining while having a bowel movement?	0	1	2	3
Unable to complete a bowel movement?	0	1	2	3
Rectal bleeding?	0	1	2	3
Have you been losing weight?	0	1	2	3