Hunterdon Pediatric Associates
Parent / patient check-list for
Abdominal Pain Evaluation

Patient's name_____ Date of birth_____ Today's Date_____

We would like to gather some information from you about your abdominal pain. Please write your answers to these questions and the doctor or nurse practitioner will review them with you during your visit. Please complete both sides of the paper and give it to the doctor or nurse practitioner in the examination room. Please circle Yes or No, or fill in the blank.

When did the pain begin? (How long have you had it?)_____

How intense is the pain on a scale of one to ten? ____/10
How often do you have the pain? **(Circle one)**

More than once a day
Once a day
A few times a week
Once a week
Less than once a week

Do you have the pain on weekdays, weekends or both? **(Circle one)**

Is the pain continuous all the time, or does it come and go? **(Circle one)**
Is there a time of day when it bothers you most? When? _____
Is the pain related to eating? **Yes/No** If so, how?
How is your appetite? _____

Where is the pain located in your belly? **(Circle one)**

Upper (near rib cage)
Around the belly button
Lower (below the belly button)
Left side
Right side
All over

What does the pain feel like? (sharp, burning, squeezing, etc)_____
What makes it better? _____
What makes it worse? _____

Do you feel the pain in your back? **Yes/No** Your legs? **Yes/No**
Do you have pain in your chest? **Yes/No** Do you cough? **Yes/No**
Do you burp a lot? **Yes/No**
Do you get sore throats or an acid taste? **Yes/No**

Does the pain wake you from sleep? **Yes/No**
Do you vomit (throw up)? **Yes/ No**
Do you have diarrhea? **Yes/ No**
Do you have constipation (hard, painful stool)? **Yes/No**
How often do you have a bowel movement? _____
What color is your stool?_____ Is there any blood? **Yes/No**
Do you have much gas? **Yes/No**
Have you had any unusual weight gain or loss? **Yes/No**

Do you have any trouble with your urine? (frequency, urgency, burning, bad odor, odd color, accidents, etc) (circle those that apply) **Yes/No**
Do you have unexplained fevers? **Yes/No**
Was there an injury to the belly or back? **Yes/No**
Joint Pain? **Yes/No**
Rashes? **Yes/No**

For females: Age at first menstrual cycle_____ Frequency of cycles_____
Date of last period_____Relationship between pain and cycle? **Yes/No**

What medicines, supplements or herbal products do you take?

Have you traveled? If yes, give details. **Yes/No**
Do you eat uncooked fish or meat? If yes, give details**.** **Yes/No**
Are you exposed to any animals? If yes, give details. **Yes/No**
Family history of gastrointestinal or kidney diseases? **Yes/No**
If yes, please write details.

Are you anxious? Do you feel depressed? **Yes/No**
How are things going at school?
How are things going in your family?
Any new or unusual stresses?