Pediatrics, P.C.
Infancy through Adolescence

ABDOMINAL PAIN QUESTIONNAIRE

NAME:_____ **DATE:**_____

1) How long have you had abdominal pain? _____

2) Where is the pain usually located? _____

3) How long does it last? _____

4) During what time of the day does it occur? _____

5) Is there any pattern to this pain? _____

6) Has this pain been associated with any fever, vomiting, diarrhea or bowel habit change ? _____

7) Is there any connection between this pain and the ingestion of certain foods or drinks? _____

8) How much milk do you drink per day? _____

9) How much carbonated beverages do you drink per day (soda/pop) ?_____

10) Is there a family history of abdominal pain or bowel problems? _____
If so, what kind of problem? _____

11) Has there been any associated weight gain or weight loss? _____

12) What makes the pain better or go away? _____

13) Have you been taking any medication for this pain? _____

14) Have you increased stress at school? _____

15) Have you had any stress in the family? (Death, Divorce, etc.) _____

16) Are any symptoms related to the urinary system? _____

17) How much gum do you chew per day? _____ Sugarless? _____

18) Is there any history of trauma to the abdomen? _____

19) Does the pain awaken you at night? _____

20) Were there any food intolerances or "colic" as an infant? _____

21) Do you take any kind of medications daily? _____