Name: _____SSN:_____

Complaint: Abdominal Pain

When did the pain begin? _____

Severity:
On a scale of 0-10 (0 being no pain and 10 being the worst pain imaginable) what is the current pain level? _____

Status:

Improved No Change Worse Resolved

Other_____

Frequency:

Random Constant Daily Monthly Weekly

Location:

Please refer to **page 4** for diagram.

Does the Pain Travel Anywhere?

Back Chest Groin Left Flank

Neck Pelvis Perineum Rectum

Right Flank Shoulder Other _____

Quality:

Aching Blotting Burning Colicky

Dull Gnawing Sharp Stabbing

Throbbing Other_____

Context:

After Bowel Movement After Meals After Surgery Empty Stomach

Lying Down No Pattern Noted On Urination Ostomy

Wakes from Sleep With Bowel Movement

Name: _____SSN:_____

Aggravated By:

Alcohol	Anxiety	Bending Over	Bowel Movement
*Brassica Vegetables	Constipation	Exercise	Fatty Foods
Food	Heavy Meals	Intercourse	Lying Down
Medications	Dairy Products	movement	Nothing
NSAIDS	Physical Exertion	Pressure to the Abdomen	
Prolonged Sitting	Prolonged Standing	Respirations	Spicy Foods

Relieved By:

Analgesics	Antacids	Bowel Movement	Change in Position
Eructation	Flatus	Food	H2 Blockers
Lying Down	Nexium	Prevacid	Prilosec OTC
Protonix	Physical Exertion	Pressure to the Abdomen	
Proton Pump Inhibitors		Rest	Vomiting

Associated Symptoms/ Pertinent negatives (Some will not apply).

Acid Regurgitation	Back pain	Blotting	Blood in Stool
Blood in Urine	Change in Appetite	Constipation	Diaphoresis
Diarrhea	Dizziness	Dyspnea	Eructation
Fatigue	Fever	Flank Pain	Flatulence
Flushing	Heartburn	Jaundice	Lightheadedness
Menstruation	Myalgias	Nausea	Rash
Vaginal Bleeding	Vaginal Discharge	Weight Gain	Weight Loss
No Associated Symptoms	No Pertinent Negatives		None

* Brassica Vegetables: Cabbage or variations of cabbage, bustle sprouts, broccoli, and beets.

Name: _____SSN:_____

Sleep Limitations:

Falling asleep Staying asleep Getting back to sleep

Not able to sleep on affected side Able to sleep on affected side

Awakening too early Waking # time per night _____

Please list all of your allergies. (None)

Recent Travel Out of the Country?

No Yes Where _____

Reptile Pets? No Yes What Kind? _____

Recent Ingestion of Well Water? Yes No Where? _____

Name: _____SSN:_____

Type of Pain You Are Currently Experiencing…
Place appropriate symbol or Letter on the Diagram
Ache= AAAA
Numbness= NNNN
Pins And Needles= OOOO
Burning= XXXX
Stabbing= ////