GULF COAST SURGICAL CLINIC

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ABDOMINAL PAIN EVALUATION

1. How long have you had this pain?_____

2. What brought it on initially?_____

3. How long does it usually last?_____

4. How often does it occur?_____

5. What makes it better?_____

6. What makes it worse?_____

7. What, if any, medication(s) do you take for this pain?_____

8. Have you ever been evaluated by another physician for this problem?_____

   If yes, what tests were completed and where did you have them done?_____

9. Please rate the intensity of your pain on a scale of **1** through **10**. Circle the appropriate number:

1 2 3 4 5 6 7 8 9 10
mild **moderate** **severe**

10. Please circle all of the phrases below that describe the location of your pain:

mid-upper stomach	***around the navel***	***right groin***	***right, below rib area***
below navel, right side	***left groin***	***left, below rib area***	***below navel, left side***
all across belly, below navel	***all across upper abdomen***	***goes back on right***	***goes back on left***

11. Please circle all below that describe your type of pain:

constant	***aches***	***worse after certain foods***	***intermittent***	***cramps***
better with food	***sharp***	***piercing***	***stinging***	***burning***
throbbing	***with certain movements***		***associated with monthly cycle***	

12. Please circle all other symptoms you have:

nausea	***vomiting***	***bloating***	***flatulence***	***belching***	***heartburn***	***diarrhea***
muscle aches	***headache***	***constipation***	***bulging mass***	***tiredness***	***dizziness***	***fever***
runny nose	***cough***	***blood in urine***	***strong odor to urine***	***chest pain***	***bulging mass that changes***	
difficult urination		***burning with urination***		***vaginal discharge***		

date of last menstrual cycle:_____

Patient signature:_____ Date:_____ Phys. Rev.:_____