FBDSI

Today’s Date: __ __/ __ __/ __ __    SID: __ __ __ __ __

1. PAIN: Please place a vertical mark (|) that indicates the amount of abdominal pain you felt TODAY:

|______________________________________________________|

None                                                                     Very Severe

2. Over the past SIX (6) months, have you had continuous or frequently recurring pain in your abdomen? (If you are female, this should NOT be related to your menstrual cycle or period.)

   ○ 1. Yes
   ○ 0. No or rarely [If No, please skip to Question 5]

3. (If Yes) Is the pain constant (i.e., present all the time and everyday)?

   ○ 1. Yes
   ○ 0. No

4. Does your abdominal pain interfere with your daily activities? (For example, inability to work or decrease in social events)

   ○ 1. Never
   ○ 2. Rarely
   ○ 3. Sometimes
   ○ 4. Often
   ○ 5. Always

5. How many times in the last six (6) months have you been to a physician for your gastrointestinal symptoms? __ __ times

Thank you for completing this questionnaire. Your completed questionnaire will remain confidential.