Gastro-intestinal disorders questionnaire - Physician

Full name:

Application number:

1. Please state the precise diagnosis.

2. Regarding your patient's symptoms:
   a) When did the symptoms first occur?

   b) How frequently do symptoms occur, e.g. how often in the last 12 months?

   c) When was the last occurrence of symptoms?

   d) Please comment on the of severity of symptoms.

   e) Are the symptoms exacerbated by any particular factor such as stress, diet, or alcohol? Yes ☐ No ☐
   If YES, please provide details.

3. Regarding your patient's medical care:
   a) Has your patient been investigated for this condition? Yes ☐ No ☐
   If YES, please provide details including type of investigation, results and dates.

   b) Has any surgery been carried out, or is surgery being considered? Yes ☐ No ☐
   If YES, please provide date(s) and complete details.

   c) Please provide details of any medication used (prescription or over the counter) in the last two years including drug name and frequency taken.

   d) Has the patient completely recovered from the condition? Yes ☐ No ☐
   If NO, please provide the details on current status and prognosis.

4. Please give any information you may have on your patient's alcohol consumption and smoking habits.

5. Please advise dates and duration of any time off work due to the condition.

6. Please comment on any other relevant features or co-morbid conditions which may influence the prognosis of the disorder.

Signature

Date

Please print name and add clinic stamp