Healthy Gut Questionnaire

Name_____ Birthdate_____ Date_____

History: Please indicate if any of the following applies to you.

Approximate number of times **antibiotics was used during childhood**?	☐0-1 times	☐2-3 times	☐4+ times
Within the **last 5 years**, have you used any antibiotics?	☐YES	☐NO	☐Unknown
Are you currently taking any **opiate pain medication**?	☐YES	☐In the past	☐NO
Are you currently using **illicit drugs**?	☐YES	☐In the past	☐NO
Are you currently taking any **proton pump inhibitors**? - If YES, for how long? _____	☐YES	☐In the past	☐NO
Are you currently using long-term **corticosteroids**?	☐YES	☐In the past	☐NO
Are you currently using any **anti-diarrheals**?	☐YES	☐In the past	☐NO
Have you ever had **thrush**, **vaginal yeast infections** or **fungal skin rashes**?	☐YES	☐In the past	☐NO
Have you ever had **food poisoning**? - If YES, how long ago? _____	☐YES	☐In the past	☐NO
Do you have a history of **diabetes**? - If YES, what type? _____	☐YES	☐NO	☐Unknown
Have you been told that you have a problem with **gut motility** (including **gastroparesis, delayed transit time**, etc.)?	☐YES	☐NO	☐Unknown

Do you have a history of any of the following?					
Amyloidosis	☐YES	☐NO	Ileocecal valve removal	☐YES	☐NO
Anatomical or Structural abnormalities	☐YES	☐NO	Immunodeficiency (AIDS, or IgA deficiency, etc.)	☐YES	☐NO
Anemia	☐YES	☐NO	Intraabdominal adhesions	☐YES	☐NO
Celiac Disease	☐YES	☐NO	Liver Cirrhosis	☐YES	☐NO
Chronis pancreatitis	☐YES	☐NO	Low Stomach Acid	☐YES	☐NO
Crohn's Disease	☐YES	☐NO	Osteoporosis	☐YES	☐NO
Cystic fibrosis	☐YES	☐NO	Parkinson's	☐YES	☐NO
Ehlers Danlos, Marfan's or another joint hypermobility syndromes	☐YES	☐NO	Rosacea	☐YES	☐NO
Gastric bypass surgery	☐YES	☐NO	Scleroderma	☐YES	☐NO
Fibromyalgia	☐YES	☐NO	Ulcerative Colitis	☐YES	☐NO

Bowel Movements: Please indicate if any of the following applies to you.

How often do you have **bowel movements**?	☐Every other day	☐Only a couple times per week	☐0-1 per day	☐2-3 per day	☐4+ per day
Do you have **undigested food in your stool**?	☐Only a couple times per month	☐Only a couple times per week	☐Every other day	☐At least once a day	☐With every bowel movement
What is the **color of your stool**?	☐Yellow	☐Orange	☐Light brown	☐Dark brown	☐Black
Have you ever noticed any **blood in your stool**?	☐Never	☐Only on toilet paper	☐Rarely	☐A few times	☐Every time
What is the **consistency of your stool**?	☐Watery	☐Loosely formed	☐Soft & formed	☐Hard & formed	☐Hard small peas
Have you ever noticed anything that looked like **coffee grounds in your stool?**	☐Regularly		☐Rarely	☐NEVER	
Is your **stool easy to pass**?	☐Regularly		☐Rarely	☐NEVER	
Do you have **urgency** with your bowel movements?	☐Regularly		☐Rarely	☐NEVER	
Do you **notice fat or greasiness** in your stool?	☐Regularly		☐Rarely	☐NEVER	
Does your **stool float**?	☐Regularly		☐Rarely	☐NEVER	

Bloating: Please indicate if any of these symptoms are present.

Do you experience any **bloating or distention**?	☐YES	☐NO	☐ Sometimes
- If YES, *when is your bloating or distension the worst?*	☐Only **Before** meals	☐Only **After** meals	☐All the time
- If YES, *what time of day symptoms are the worst?*	☐When you wake up	☐End of the day	☐All the time

Additional Symptoms: Please indicate if any of these symptoms are present.

Do you experience any **abdominal pain, cramping or discomfort**?	☐YES	☐NO
If YES, please answer the following questions:		
- Is the pain ***worse*** *after eating*?	☐YES	☐NO
- Is the pain ***better*** *after eating*?	☐YES	☐NO
- Is the pain ***constant***?	☐YES	☐NO
- Do you ***wake up*** *with abdominal pain*?	☐YES	☐NO
- Do you experience your abdominal pain *at least* ***once a week***?	☐YES	☐NO
- Have you experienced your abdominal pain for the *last* ***three months or longer?***	☐YES	☐NO
- Do you notice your abdominal pain ***improves*** with passage of stool?	☐YES	☐NO
Do you experience any **flatulence** (passing of gas) **or belching**?	☐YES	☐NO

Do you experience any **nausea**?	☐YES	☐NO
Do you experience any **vomiting**? - If YES, does it burn?	☐YES ☐YES	☐NO ☐NO
Have you found that your symptoms are **triggered by any foods**? If YES, do you find that *apples, onions and garlic* are noticeable triggers?	☐YES ☐YES	☐NO ☐NO
Do you experience any **brain fog, confusion** or **difficultly thinking**?	☐YES	☐NO
Do you experience **noticeably bad breath even with brushing**?	☐YES	☐NO
Do you experience any **indigestion** or **heartburn**?	☐YES	☐NO
Do you experience any **anal itching or irritation**?	☐YES	☐NO
Do you experience a **sense of fullness** soon after starting a meal?	☐YES	☐NO
Do you have **difficultly digesting meat**?	☐YES	☐NO
Do you experience any **dizziness** or **light-headedness?**	☐YES	☐NO
Do you experience any **fatigue** or **tiredness**?	☐YES	☐NO
Do you notice that you **bruise easily**?	☐YES	☐NO
Do you experience any **fluctuation in mood**?	☐YES	☐NO
Do you experience any **unexpected weight loss** or have **difficulty gaining weight**?	☐YES	☐NO
Do you experience any **intolerance to temperature fluctuation**?	☐YES	☐NO
Do your symptoms increase with **aspirin** or other **food sources of salicylates** (most berries, watermelon, avocado)?	☐YES	☐NO