NORTHWEST ALLIED
BARIATRIC & FOREGUT SURGERY

Gastroparesis Screening Questionnaire

Patient Name:______________________________ DOB:___/___/_____Date:____________

Weight Loss :_______ lbs_____wks

HOW DID YOU HEAR ABOUT US?
___ Primary Care Physician (PCP) Name?
___ Referring Specialist (Gastroenterologist, ENT, Pulmonologist): Name?___________________
___ Personal: Another Patient, Family Member, or Friend
___ Marketing (please circle): Website Seminar Billboard Other(please list):

How many doctor's visits have you had in the last year because of symptoms? ________

How many times did you go to the ER/Hospital last year? _______

Have you had and EGD? Yes___ No___

Have you had a Gastric Emptying Study? Yes___ No___

Have you had abdominal surgery? Yes__ No___ If yes what procedure and when?

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Have you been treated with any of these medications?

Reglan Dose________ Duration______ **Zofran** Dose_______ Duration_______
Erythromycin Dose_______ Duration_______ **Phenergan** Dose_______ Duration_______
Domperidone Dose_______ Duration_______ **Scopolamine** Dose______ Duration_______
Other _______________ Dose_______ Duration_______

For office use only:
Therapy Recommendation: Botox J-G Tube Enterra Therapy Pyloroplasty Gastrectomy

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Gastroparesis Questionnaire Intake Form

Name ____________________________________ DOB _____/____/______ Date______________

Gastroparesis Cardinal Symptom Index (GCSI)

The following are validated questionnaires to determine severity of symptoms you may have related to your gastrointestinal problem. There are no right or wrong answers. For each symptom, please circle the number that best describes how severe the symptom has been during the past 2 weeks.

	None	Very Mild	Mild	Moderate	Severe	Very Severe
1. Nausea (feeling sick to your stomach as if you were going to vomit or throw up)	0	1	2	3	4	5
2. Retching (heaving as if to vomit, but nothing comes up)	0	1	2	3	4	5
3. Vomiting	0	1	2	3	4	5
4. Stomach fullness	0	1	2	3	4	5
5. Not able to finish a normal-sizes meal	0	1	2	3	4	5
6. Feeling excessively full after meals	0	1	2	3	4	5
7. Loss of appetite	0	1	2	3	4	5
8. Bloating (feeling like you need to loosen your clothes)	0	1	2	3	4	5
9. Stomach or belly visibly larger	0	1	2	3	4	5

This questionnaire asks you to determine the severity of your symptoms. Please circle the answer that best describes your experience when you are NOT on medication.

Scoring Scale

0 = No symptoms	3 = Symptoms bothersome every day
1 = Symptoms noticable, but not bothersome	4 = Symptoms affect daily activities
2 = Symptoms noticable & bothersome, but not every day	5 = Symptoms are incapacitating, unable to do daily activities

GERD-HRQL (Measures Typical Symptoms)

1) How bad is your heartburn? (if not taking medications)	0	1	2	3	4	5
2) Heartburn when lying down ? (if not taking medications)	0	1	2	3	4	5
3) Heartburn when standing up? (if not taking medications)	0	1	2	3	4	5
4) Heartburn after meals? (if not taking medications)	0	1	2	3	4	5
5) Does heartburn change your diet? (if not taking medications)	0	1	2	3	4	5
6) Does heartburn wake you from sleep? (if not taking medications)	0	1	2	3	4	5
7) Do you have difficulty swallowing? (if not taking medications)	0	1	2	3	4	5
8) Do you have pain with swallowing? (if not taking medications)	0	1	2	3	4	5
9) Do you have bloating or gassy feelings? (if not taking medications)	0	1	2	3	4	5
10) If you take medication, does this affect your daily life?	0	1	2	3	4	5

11) How satisfied are you with your present condition? Satisfied Neutral Dissatisfied

GERD-HRQL TOTAL SCORE: