

ABDOMINAL PAIN DIARY

Start date of pain: _____ Underwear Staining? Yes/No

Family history of abdominal pain? Yes/No Constant?/Come and go? Yes/No

Does it prevent normal activities? Yes/No Related to food/meals? Yes/No

Location/Does it move? Yes/No Known stressors? Yes/No

Day of Week and Date	Time(s)	Severity* 0 - 10	Where? Home/School	Sharp/Dull/ Crampy?	BM** Hard/Soft?	Anything Make Better?	Any Other Symptoms?	Other Info?

*Scale: "0" is no pain and "10" is worst pain of life

**Bowel movement

Patient Name: _____ DOB: _____

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