

Food, Fluids & Digestion

Please describe the main issue:

When did it start?	What triggered it?
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How has it changed?	How does it limit you?
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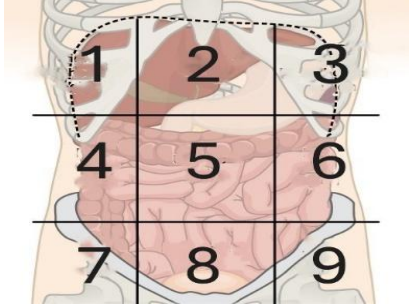
<p>What makes it better:</p> <ul style="list-style-type: none"> <input type="radio"/> Eating <input type="radio"/> Fasting <input type="radio"/> Hot food/drink <input type="radio"/> Cold food/drink <input type="radio"/> Pressure <input type="radio"/> Loose clothing <input type="radio"/> Passing gas <input type="radio"/> Opening bowels <input type="radio"/> Resting <input type="radio"/> Activity 	<p>What makes it worse:</p> <ul style="list-style-type: none"> <input type="radio"/> Eating <input type="radio"/> Fasting <input type="radio"/> Heat inc. food & drink <input type="radio"/> Cold inc. food & drink <input type="radio"/> Pressure <input type="radio"/> Diet choices <input type="radio"/> Stress <input type="radio"/> Opening bowels <input type="radio"/> Resting <input type="radio"/> Activity
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<p>Do you get?</p> <ul style="list-style-type: none"> <input type="radio"/> Pain <input type="radio"/> Distension/bloating <input type="radio"/> Reflux <input type="radio"/> Nausea or vomiting <input type="radio"/> Indigestion (dyspepsia) <input type="radio"/> Gnawing hunger <input type="radio"/> A lack of appetite <input type="radio"/> Haemorrhoids <input type="radio"/> Bleeding gums <input type="radio"/> Mouth ulcers or cold sores <input type="radio"/> Bad breath <input type="radio"/> Sudden weight changes & puffiness 	<p>Tests: have you had?</p> <ul style="list-style-type: none"> <input type="radio"/> Endoscopy <input type="radio"/> Colonoscopy <input type="radio"/> X-ray, MRI, PET or ultrasound scan <input type="radio"/> Biopsy <input type="radio"/> Barium meal/SmartPill camera <input type="radio"/> <i>H. pylori</i> test <input type="radio"/> Nutritional tests <input type="radio"/> A Digestive analysis <input type="radio"/> Food intolerance test <input type="radio"/> Microbiome analysis <input type="radio"/> Breath tests (SIBO types) <input type="radio"/> Blood tests
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<p>Appetite: how's yours? (Low – High: 1 – 10)</p> <ul style="list-style-type: none"> <input type="radio"/> First thing <input type="radio"/> Noon <input type="radio"/> 5-7 pm <input type="radio"/> Evening 	<p>Altered taste: do you experience?</p> <ul style="list-style-type: none"> <input type="radio"/> Loss of taste <input type="radio"/> Metallic <input type="radio"/> Bitter <input type="radio"/> Other
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Do you follow a particular diet?	Have food-related issues affected you?
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<p>Thirst: do you tend to:</p> <ul style="list-style-type: none"> <input type="radio"/> Sip drinks <input type="radio"/> Gulp drinks <input type="radio"/> Drink hot drinks 	<ul style="list-style-type: none"> <input type="radio"/> Drink cold drinks <input type="radio"/> Drink during the night <input type="radio"/> No strong preferences for the above
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<p>Pain/discomfort: do you get?</p> <ul style="list-style-type: none"> <input type="radio"/> None <input type="radio"/> Dull & nagging <input type="radio"/> Sharp <input type="radio"/> Cramping or stabbing <input type="radio"/> Burning 	<ul style="list-style-type: none"> <input type="radio"/> In waves <input type="radio"/> Fixed <input type="radio"/> Distending <input type="radio"/> Linked to the cycle <p>Location:</p> <ul style="list-style-type: none"> <input type="radio"/> 1 - Right upper quadrant <input type="radio"/> 2 - Epigastric <input type="radio"/> 3 - Left upper quadrant <input type="radio"/> 4 - Right lumbar <input type="radio"/> 5 - Umbilical <input type="radio"/> 6 - Left lumbar <input type="radio"/> 7 - Right iliac <input type="radio"/> 8 - Suprapubic <input type="radio"/> 9 - Left iliac <input type="radio"/> 10 - Elsewhere
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<p>Typical diet:</p> <p>Breakfast</p> <p>Lunch</p> <p>Evening meal</p>	<p>Time</p>	<p>Snacks & types of drinks</p>
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<p>Bowels: do they usually open?</p> <ul style="list-style-type: none"> <input type="radio"/> Every 2-3 days <input type="radio"/> Once a day <input type="radio"/> 2-3 times a day <input type="radio"/> 4+ times a day <input type="radio"/> Soon after eating 	<p>Do your stools contain/come with?</p> <ul style="list-style-type: none"> <input type="radio"/> Undigested food (except nuts and seeds) <input type="radio"/> Mucus <input type="radio"/> Fresh blood <input type="radio"/> Dark blood <input type="radio"/> Get an unproductive urge to defecate
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<p>Is opening the bowels</p> <ul style="list-style-type: none"> <input type="radio"/> Easy <input type="radio"/> Difficult or slow <input type="radio"/> Urgent 	<ul style="list-style-type: none"> <input type="radio"/> Associated with pain or discomfort <input type="radio"/> With an incomplete feeling <input type="radio"/> Alternating constipation & diarrhoea <input type="radio"/> Affected by stress
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<p>Your Bristol Stool Chart choices:</p> <ol style="list-style-type: none"> 1. Hard lumps like nuts 2. Sausage-shaped but lumpy 3. Sausage-like with cracks on the surface 4. Smooth, soft sausage/snake 5. Soft blobs with clear-cut edges 6. Fluffy blobs with ragged edges 7. Watery, without solid pieces 	<p>Colour – please choose all that can occur</p> <ul style="list-style-type: none"> <input type="radio"/> Yellow <input type="radio"/> Pale brown <input type="radio"/> Mid brown <input type="radio"/> Dark brown <input type="radio"/> Black <input type="radio"/> Like coffee grounds
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<p>Intestinal Wind</p> <ul style="list-style-type: none"> <input type="radio"/> Very little <input type="radio"/> Too much 	<ul style="list-style-type: none"> <input type="radio"/> Causes discomfort <input type="radio"/> Little odour <input type="radio"/> Foul-smelling
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<p>Bladder: do you get?</p> <ul style="list-style-type: none"> <input type="radio"/> No problems <input type="radio"/> Pain or discomfort when urinating <input type="radio"/> Pain or discomfort after urinating <input type="radio"/> Cloudy urine 	<ul style="list-style-type: none"> <input type="radio"/> Problems with urinary flow <input type="radio"/> Urinary frequency or urgency <input type="radio"/> Leaking or dribbling <input type="radio"/> Smelly urine <input type="radio"/> Blood in urine
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<p>Tests: have you had?</p> <ul style="list-style-type: none"> <input type="radio"/> Urinalysis <input type="radio"/> Dip stick tests 	<ul style="list-style-type: none"> <input type="radio"/> Urodynamic tests <input type="radio"/> Imaging of the bladder or kidneys <input type="radio"/> Prostate treatment
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