Patient Name: _____

DOB: _____

Abdominal Pain Diary

	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Start and end time of pain	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____
Type of pain (ache, sharp, throbbing, radiating to another area)						
Location of pain (right, left, middle, lower, back, chest)						
Intensity of pain (circle one)	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
List foods/drinks in last 4 hours						
Other symptoms? (light or noise sensitivity, nausea, vomiting, headache, diarrhea, heartburn)						
Anything make it worse?						
Anything make it better?						
How many hours slept last night?						
Other things you've noticed?						

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