HEALTHY GUT QUESTIONNAIRE

Name: _______________________________ Birthdate: _____________ Date: ____________

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

Approximate number of times **antibiotics were 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 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 **medications for diarrhea?**	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
Have you been told that you have a problem with **gut motility** (ex: **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	YES	NO
Anemia	YES	NO	Intra-abdominal adhesions	YES	NO
Celiac disease	YES	NO	Liver cirrhosis	YES	NO
Chronic pancreatitis	YES	NO	Low stomach acid	YES	NO
Crohn's disease	YES	NO	Osteoporosis	YES	NO
Cystic fibrosis	YES	NO	Parkinson's	YES	NO
Diabetes Mellites	YES	NO	Psoriasis or Eczema	YES	NO
Ehlers-Danlos, Marfan's or another joint hypermobility syndrome	YES	NO	Rosacea	YES	NO
			Scleroderma	YES	NO
Gastric bypass surgery	YES	NO	Sjogren's	YES	NO
Fibromyalgia	YES	NO	Ulcerative Colitis	YES	NO

What is the consistency of your stool?

Watery, no solid pieces	Fluffy pieces with ragged edge, mushy	Soft blobs with clear cut edges	Smooth and soft snake	Like a sausage with cracks in surface	Sausage shaped but lumpy	Separate hard lumps, like peas, hard to pass

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

How often do you have **bowel movements**?	Couple times per week	Every other day	1 per day	2-3 per day	4+ per day
Do you have **undigested food in your stool**?	None	A couple times per month	A couple times per week	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
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 the bloating or distension the worst?*	Only **Before** meals	Only **After** meals	All the time
- If YES, *what time of day are symptoms the worst?*	When you wake up	End of the day	All the time

Abdominal Discomfort: Please indicate if any of these symptoms are present.

Do you experience any **abdominal pain, cramping or discomfort**? If YES, please answer the following questions:	YES	NO
- 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 abdominal discomfort *at least* ***once a week?***	YES	NO
- Have you experienced abdominal discomfort for the *last* ***3 months or longer?***	YES	NO
- Do you notice that your abdominal discomfort is ***associated with a change in your bowel movements?***	YES	NO
- Do you notice your abdominal pain ***improves*** with passage of stool?	YES	NO

Do you experience any of the following symptoms that are severe enough to interfere with your regular activities?		
- **Postprandial fullness** (full right after eating)	YES	NO
- **Early satiety** (get full very quickly while eating)	YES	NO
- **Epigastric pain** (pain just below ribcage)	YES	NO
- **Epigastric burning** (burning just below ribcage)	YES	NO
- Have these symptoms occurred **at least 3 days a week for the last 3 months?**	YES	NO
- Did these symptoms begin over **6 months ago?**	YES	NO

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

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
Do you experience any **indigestion** or **heartburn**?	YES	NO
Have you found that your symptoms are **triggered by any foods**? - Are *apples, onions and garlic* noticeable triggers? - Are *aged meats & cheeses, wine, tomatoes,* and *vinegar* triggers? - Other triggers: ____	YES YES YES	NO NO NO
Do you experience **hives**?	YES	NO
Do you get **rashes easily or feel like your skin flushes easily**?	YES	NO
Do you experience any **brain fog, confusion** or **difficultly thinking**?	YES	NO
Do you experience any **anal itching or irritation**?	YES	NO
Do you have **difficultly digesting meat**?	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

Oral Health: Please indicate if any of these symptoms are present.

Do you experience **noticeably bad breath even with brushing**?	YES	NO
Do you **floss** at least 3-4 times a week?	YES	NO
Do your **gums bleed** frequently?	YES	NO
Has your dentist mentioned that you have gum **pocket depth** greater than 3mm?	YES	NO
Do you have a history of **gingivitis** or **multiple dental caries**?	YES	NO

FUNGUS RELATED DISEASE QUESTIONNAIRE-7 (FRDQ-7)

Questions:	**0 points**	**1 point**	**2 points**	**3 points**
Have you, at any time in your life, taken broad spectrum antibiotics?	NO	-	-	YES
Have you taken tetracycline or other broad spectrum antibiotics for one month or longer?	NO	-	-	YES
Are your symptoms worse on damp, muggy days or in moldy places?	NO	-	-	YES
Do you crave sugar?	NO	-	-	YES
Do you have a feeling of being "drained"?	None	Occasional or Mild	Frequent of moderately severe	Severe or disabling
IF APPLICABLE: Are you bothered with vaginal burning, itching or discharge? OR IF APPLICABLE: Do you have burning, itching or discharge from the penis?	None	Occasional or Mild	Frequent of moderately severe	Severe or disabling
Are you bothered by burning, itching or tearing of your eyes?	None	Occasional or Mild	Frequent of moderately severe	Severe or disabling

Total points per column: ___________ = ___________ + ___________ + ___________ + __________

Scoring: 0-3 = unlikely; 4-9 = probable; 10-21 = almost certain

Reference:

Santelmann, Heiko et al. "Effectiveness of nystatin in polysymptomatic patients. A randomized, double-blind trial with nystatin versus placebo in general practice." *Family practice.* 18,3 (2001): 258-65.