



Patient I.D. plate

DIVERTICULITIS RISK FACTORS QUESTIONNAIRE

Please answer the following questions truthfully and to the best of your abilities

ALL INFORMATION GIVEN WILL BE STRICTLY CONFIDENTIAL

FAMILY HISTORY

1. Has a member of your extended family (blood relatives) ever been diagnosed with diverticular disease (diverticulosis, diverticulitis)? *Check all that apply*

- Mother
- Father
- Sibling
- Grandparent
- Aunt/Uncle (blood relatives)
- Cousin
- Distant blood relative
- Other: _____

If any boxes were checked, please specify: maternal/paternal, age of diagnosis, and course of treatment (antibiotics, hospitalization, elective surgery, etc.)

PERSONAL HEALTH HISTORY

1. Have you ever been diagnosed with any of the following conditions? *Check all that apply*

- Hypothyroidism
- Diabetes
- Polycystic Kidney Disease
- Allergies
- Coronary Heart Disease
- Chronic Kidney Failure
- Hyperuricemia
- HIV
- Colon Cancer
- Bowel Obstruction
- Crohn's Disease

2. Have you ever smoked?

- No
- Yes – if so, how many packets per day and for how long: _____

3. Do you drink alcoholic beverages?

- No
- Yes – if so, how many drinks a week: _____

4. Have you ever done any recreational drugs (ex: marijuana, cocaine, heroin, methamphetamine, etc.)?

- No
- Yes – if so, what drugs: _____

5. How would you rate your current health?

- Excellent
- Very Good
- Good
- Fair
- Poor

MEDICATION HISTORY

1. Have you ever taken – or are currently taking - any of the following medications listed? *Check all that apply*

- NSAIDs (Ibuprofen, Advil, Aspirin)
- Acetaminophen (Tylenol)
- Coxibs (Celecoxib, Rofecoxib)
- Opioids (Morphine, Oxycodone)
- Calcium agonists
- Statins (Atorvastatin, Simvastatin)
- Immunosuppressants (Steroids, Prednisone, Immunotherapy, eg, Remicade, Humira)

If any boxes were checked, please explain duration and reason of usage

GASTROINTESTINAL HISTORY

1. Do you regularly suffer from aches or pain in your abdomen?

- No → SKIP to #3
- Yes – if so, how often? _____

2. How bad is the ache or pain?

- Slight – does not limit activities
- Mild – able to do most activities
- Moderate – unable to do some activities
- Severe – unable to do most activities
- Worst pain possible – limits all activities

3. How many bowel movements do you have a day?

- None
- 1
- 2
- 3
- 4
- Other: _____

4. Which statement most accurately describes the consistency your stool?

- Separate hard lumps
- Well-formed sausage shape
- Soft blobs
- Watery, no solid pieces

5. Which statement most accurately describes the color your stool?

- Tan to dark brown
- Bright red
- Black
- Grey
- Yellow
- Green

6. Do you ever...? *Check all that apply*

- Strain when having a bowel movement
- Notice stool in your underwear
- Notice blood in your stool
- Pass gas unknowingly

7. Have you ever undergone any of the following studies? If so, what were the results?

- Colonoscopy: _____
- Abdomen/Pelvis CT-scan: _____

DIET HISTORY

1. How important is a healthy diet to you?

- Extremely important
- Very important
- Important
- Somewhat important
- Not important / Don't care

2. How would you rate your diet?

- Very healthy
- Healthy
- Somewhat healthy
- Unhealthy

3. Please rate how often you consumed each item while growing up:

	Never	Rarely	Somewhat Often	Often	Very Often
Fruits	<input type="checkbox"/>				
Vegetables	<input type="checkbox"/>				
Soluble Fibers (Beans, Oats, Lentils)	<input type="checkbox"/>				
Insoluble Fibers (Wheat bran, wholegrain cereals)	<input type="checkbox"/>				
Nuts (In general)	<input type="checkbox"/>				

	Never	Rarely	Somewhat Often	Often	Very Often
Popcorn	<input type="checkbox"/>				
Peanuts	<input type="checkbox"/>				
Red Meat	<input type="checkbox"/>				
Milk and Dairy	<input type="checkbox"/>				
High Carbohydrates (Bread, pasta, potato products)	<input type="checkbox"/>				
Fast-Food	<input type="checkbox"/>				
Sugary sweets	<input type="checkbox"/>				
Water	<input type="checkbox"/>				
Juice	<input type="checkbox"/>				
Soda	<input type="checkbox"/>				
Coffee	<input type="checkbox"/>				

4. Where do you most often eat your meals? *Check all that apply.*

- Home
- Fast-food chain
- Cafeteria
- Restaurants
- Other: _____

PHYSICAL ACTIVITY HISTORY

1. How physically active were you as a child?

- Very active
- Active
- Moderately active
- Slightly active
- Not active at all

2. How physically active do you consider yourself now?

- Very active
- Active
- Moderately active
- Slightly active
- Not active at all

3. How many days a week do you spend exercising?

- None → SKIP to #6
- 1
- 2
- 3
- 4
- 5
- 6
- 7

4. How much time do spend exercising in each session?

- 30 minutes or less
- 1 hour
- 2 hours
- 3 hours
- Other: _____

5. What types of physical activities do you perform during those days? *Check any that apply.*

- Aerobic – jogging, sports, etc.
- Strength – Lifting weights, resistance training, etc.
- Balance – Tai Chi, gymnastics, etc.
- Flexibility – Yoga, stretching, etc.

6. Would you describe your lifestyle as sedentary – spending large portions of the day sitting/laying down?

- Yes
- No

7. On average, how many hours per day do you spend sitting down?

- 2 hours or less
- 3-4 hours
- 5-6 hours
- 7 hours or more

STRESS HISTORY

1. On a scale from 1 to 5, 1 being not stressed at all and 5 being the most stressed, how stressed do you feel on a daily basis?

- 1 (No stress at all)
- 2
- 3
- 4
- 5 (Most stress)

Thank you for completing this questionnaire. Your participation is highly appreciated!

[Questions to be completed by attending]

1. BMI: _____

2. Recurrent Diverticulitis?

No → SKIP to #4

Yes – if so, how many episodes in the past: _____

3. Treatment/Complications for past episodes? *Check all that apply*

None

Antibiotics

Elective Surgery

Emergent Surgery

Hospitalization

Abscess

Obstruction

Fistula

Peritonitis

Percutaneous Drainage of Abscess

4. Current Treatment/Complications for past episodes? *Check all that apply*

None

Antibiotics

Elective Surgery

Emergent Surgery

Hospitalization

Abscess

Obstruction

Fistula

Peritonitis

Percutaneous Drainage of Abscess