Gastric emptying study

Patient questionnaire

Name: DOB:

Date of Study:

1. **What is your main symptom that has led to undergoing the test today?** (Please tick):

☐ heartburn ☐ chest pain ☐ nausea ☐ vomiting ☐ abdominal pain

☐ bloating/distension ☐ constipation ☐ diarrhoea ☐ unexplained hypoglycaemia

Other:

2. **Do you have diabetes?** (Please tick) ☐ No ☐ Yes

If yes, type: How long have you had diabetes?

What medication do you take? (Please tick) ☐ Insulin ☐ Tablets ☐ Subcutaneous injection

Did you measure your glucose this morning before the test? (Please tick) ☐ No ☐ Yes

If yes, what was the value?

3. **Do you take any pain medication?** (Please tick) ☐ No ☐ Yes

If yes, which one(s) and how often?

When did you last take this type of medicine?

4. **Do you take any medications to speed up your gastrointestinal tract (stomach or colon)?** (Please tick)

☐ No ☐ Yes If yes, which one(s)?

When did you last take this type of medicine?

5. **List any other medications you currently take:**

6. **Have you had surgery on your gastrointestinal tract (the oesophagus, stomach or colon)?** (Please tick)

☐ No ☐ Yes If yes, please describe:

Name of clinician completing form with patient:

Signed: Date:

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