# Gastrointestinal Symptom Questionnaire

VIATRIS

**Please take time to answer this questionnaire if you have diabetes and bowel symptoms. This questionnaire may help the conversation between you and the healthcare professional.**

Patient ID

## Section 1: Medical History

| | | | | |
|---|---|---|---|---|
| a. What is your name? | | | | |
| b. What is your date of birth? | | | | |
| c. Do you have diabetes? | ☐ Yes | | ☐ No | |
| - If yes, what type of diabetes? | ☐ Type-1 | ☐ Type-2 | ☐ Other | ☐ Unsure |
| - If yes, how long have you had diabetes? | ☐ <5 yrs | ☐ 5-10 yrs | ☐ 10-20 yrs | ☐ >20 yrs |
| d. Do you smoke? | ☐ Yes | ☐ No | ☐ Occasionally | |
| e. How often do you have a drink that contains alcohol? | ☐ Never | ☐ Monthly or less | ☐ 2-4 times a month | |
| | ☐ 2-3 times a week | | ☐ 4+ times a week | |

## Section 2: Do you experience any of the following bowel-related symptoms?

| | | |
|---|---|---|
| a. Abdominal pain | ☐ Yes | ☐ No |
| b. Bloating symptoms (this may include stomach noises, flatulence, trapped wind) | ☐ Yes | ☐ No |
| c. Abnormal bowel movements (including increased frequency, urgency, diarrhoea) | ☐ Yes | ☐ No |
| d. Fatty stool (pale colour, difficult to flush, foul smelling) | ☐ Yes | ☐ No |

e. Using the Bristol Stool Chart, please tick the box which best describes your stool type.

| Type 1 | Type 2 | Type 3 | Type 4 | Type 5 | Type 6 | Type 7 |
|---|---|---|---|---|---|---|
|  |  |  |  |  |  |  |
| ☐ Separate hard lumps, like nuts (hard to pass) | ☐ Sausage-shaped, but lumpy | ☐ Sausage-shaped, but with cracks on surface | ☐ Sausage or snake like, smooth and soft | ☐ Soft blobs withclear-cut edges (easy to pass) | ☐ Fluffy pieces with ragged edges, mushy | ☐ Watery, no solid pieces (entirely liquid) |

| | | |
|---|---|---|
| f. Do your symptoms impact your eating? (loss of appetite, diet awareness/avoidance of certain foods) | ☐ Yes | ☐ No |
| g. Unintentional weight loss | ☐ Yes | ☐ No |

## Section 3: Are any of the following well-being questions relevant to you?

| | | |
|---|---|---|
| a. Do your gastrointestinal symptoms impact your daily activities? | ☐ Yes | ☐ No |
| b. Do you change your diet in order to manage your gastrointestinal symptoms? | ☐ Yes | ☐ No |
| c. Do you have sleep disturbances due to bowel problems? | ☐ Yes | ☐ No |
| d. Do you feel you need to be close to a toilet due to bowel issues? | ☐ Yes | ☐ No |
| e. Do you feel embarrassed and/or frustrated due to your bowel symptoms? | ☐ Yes | ☐ No |
| f. Are you actively avoiding fatty food due to bowel intolerance? | ☐ Yes | ☐ No |

Thank you for completing this questionnaire.

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Provided as a service to patient support by Viatris

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