Structured Assessment Of Gastrointestinal Symptoms (SAGIS)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Clinical diagnosis (to be completed by Clinician):

Dear patient,

To effectively address your symptoms, we would appreciate if you could complete this short questionnaire. Please tell us about the severity of your symptoms during the last week. The explanation below will help you to best describe the severity. If there are any questions, please do not hesitate to ask one of our staff.

Thank you!

Your Gastroenterology Team

Items will be judged using a five point Likert scale: (only one response per item):	0 = No problem	No problem
	1 = Mild problem	Can be ignored when you do not think about it
	2 = Moderate problem	Cannot be ignored, but does not influence daily activities
	3 = Severe problem	Influencing your concentration on daily activities
	4 = Very severe problem	Markedly influences your daily activities &/or requires rest

1. Burning sensation in the oesophagus, belching and regurgitation of acid into the oesophagus (tube joining mouth and stomach)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
2. Dysphagia (difficulty swallowing)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
3. Fullness (feeling of stomach filled to capacity without relation to prior food intake)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
4. Early satiety (stomach is overfilled soon after starting to eat, disproportionate to the quantity of food taken, so that food cannot be finished)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
5. Postprandial pain or discomfort (upper abdominal symptoms start or get worse after meals)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
6. Epigastric pain / upper abdominal pain (pain between bottom edge of rib cage, below the sternum)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
7. Retrosternal discomfort (unpleasant feeling behind the chest bone)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
8. Pain or discomfort prior to defecation				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe

9. Difficulty defecating (straining or incomplete evacuation of the bowel)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
10. Constipation (reduced frequency of bowel movements, hard and lumpy stool)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
11. Loose stools (soft or liquid stool)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
12. Incontinence (inability to control stool)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
13. Urgency to defecate				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
14. Diarrhoea (increased in stool frequency, frequently associated with watery or loose stool)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
15. Loss of appetite (not feeling hungry)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
16. Abdominal cramps (spasmodic or colic like stomach pain without specified localisation)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
17. Sickness (the feeling you have before you need to vomit)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
18. Nausea (urgent feeling of the need to vomit)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
19. Vomiting (vomiting of mucus and / or gastric contents / food, or strong unproductive retching)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
20. Bloating (feeling of swelling of abdomen and excessive gas in the abdomen)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
21. Excessive gas and flatulence				
☐ *No problem*	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe
22. Excessive belching (without acid)				
☐ No problem	☐ Mild	☐ Moderate	☐ Severe	☐ Very severe

23. In your own words, what is <u>your most important</u> health concern or problem?

24. In your own words, what is <u>your second most important</u> health concern or problem?

Do you suffer from?

Headache	☐*yes* ☐*no*	**Back pain**	☐*yes* ☐*no*	**Sleep disturbances**	☐*yes* ☐*no*
Chronic fatigue	☐*yes* ☐*no*	**Depression**	☐*yes* ☐*no*	**Anxiety disorder**	☐*yes* ☐*no*

DO NOT WRITE IN THIS BINDING MARGIN