

Doctor Discussion Guide



Simply answer the questions below and take these results with you to your next gastroenterologist check-up to help you have well-informed conversations about your condition and what your next treatment steps could be.

1. How many liquid or very soft stools have you had over the **past 7 days**?

Your number: _____

2. Over the **past 7 days**, how often did you take any prescription or over-the-counter medicine, such as Imodium® or Lomotil®, to stop diarrhea? (**choose one**)

- Never
- A few times
- Most days
- Every day

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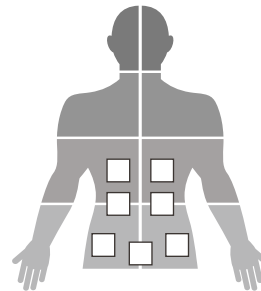
3. Have you noticed any blood in your stool in the **past week**?

- Yes
- No

4. Are you currently experiencing abdominal pain related to Crohn's disease or ulcerative colitis?
If No, skip to question 7.

- Yes
- No

5. Choose the area(s) where you are experiencing abdominal pain. (**check areas**)



6. On a scale of 1-10, how severe is your abdominal pain? (**Scale 1-10: 1 = Not severe; 10 = Very severe**)

Your number: _____

7. Have you recently experienced a change in your weight?
If No, skip the next question.

- Yes
- No

8. Approximately how much weight have you lost or gained, compared with the weight that is normal for you? **(check one and fill in)**

- Lost Gained

_____ lbs.

9. Over the past week, how many nights did you wake up because of urgent symptoms to move your bowels? **(check one)**

- None
 1-2 nights
 3-4 nights
 5-7 nights

10. **During the past month**, how many times have you changed your plans because of your symptoms?

Your number: _____

11. Are there events or activities you prefer not to attend because of your symptoms?

- Yes No

12. In the **past 6 months**, your disease has been: **(check one)**

- Constantly active—giving you symptoms every day
 Often active—giving you symptoms most days
 Sometimes active—giving you symptoms on some days (for instance, 1-2 days per week)
 Occasionally active—giving you symptoms 1-2 days per month
 Rarely active—giving you symptoms on a few days in the past 6 months
 You have been well in the past 6 months—what you consider a remission or absence of symptoms

13. Have you experienced any fevers recently?

- Yes No

14. In general, how do you feel?

- Good Fair Poor

15. How does your condition make you feel? **(check all that apply)**

- No different than normal
 Sad
 Anxious/nervous
 Afraid/frightened
 I don't know how I feel

16. Have your symptoms increased or worsened since your last doctor visit?

- Yes No

17. Which statement best describes your overall feelings about treatment? **(check one)**

- I don't have any concerns right now—my treatment is fine
 I wonder if there are other treatments available for me
 I have symptoms, but I want to do as little as possible to make them subside
 I just want to feel better—and I'm willing to do whatever it takes
 I don't know how I feel about treatment

Now that you have answered these questions, please share this checklist with your doctor at your next visit. Understanding your symptoms and the impact they have on your life will help your doctor develop a treatment plan that's right for you.