Supplemental Figure 3

Cincinnati Children's Hospital Medical Center

Inflammatory Bowel Disease
Outpatient Clinic Note - Patient

To be completed by patients who are 9 years of age or older.

Reason for Today's Visit

What is the reason for your visit today?

☐ Routine Follow-Up
☐ Sick Visit

What is your major concern today?

_____
_____
_____

Patient Global Assessment

General Well-Being
☐ Very Well ☐ Alright ☐ Poor ☐ Very Poor ☐ Terrible

Please use this space to add any comments you may have about your answers

Use the following scales to rate how you feel overall:

Today *(Check the box above the appropriate rating)*

BEST									WORST
10	9	8	7	6	5	4	3	2	1

The best I have felt in my life *(Check the box above the appropriate rating)*

BEST									WORST
10	9	8	7	6	5	4	3	2	1

How confident are you in managing your disease?
(Check the box above the appropriate rating)

VERY CONFIDENT									NOT CONFIDENT
10	9	8	7	6	5	4	3	2	1

Recent History (1 week before this visit)

In the past week, please rate the following:

Please use this space to add any comments you may have about your answers

Abdominal Pain
☐ None ☐ Mild ☐ Moderate ☐ Severe

Stools (bowel movements)
Average number of stools per day: _____

Most stools are: ☐ Formed (solid) ☐ Partially formed (loose) ☐ Liquid (watery)

Average number of liquid (watery) stools per day (0 if none): _____

How many stools have blood in them? ☐ None ☐ Less than half ☐ More than half

If stools have blood, it is usually: ☐ Small amount ☐ Large amount

Nighttime diarrhea (wake up at night with diarrhea): ☐ Yes ☐ No

Limitations in Daily Activities
☐ None ☐ Occasionally ☐ Frequently

How often do you miss school?
☐ None ☐ Occasionally ☐ Frequently ☐ All the time

Patient Print Name **Patient Signature**