Gastric Emptying Questionnaire

Name: **Height:**

Weight:

1. What is your **main symptom** for undergoing the GE test today? (Please circle the best answer or write in):
   Heartburn, chest pain, nausea or vomiting
   Abdominal pain, bloating/distension, constipation or diarrhea
   Other symptoms:

2. Do you have **diabetes? No Yes**
   If yes, how long have you had diabetes?_____years
   Did you measure your glucose this morning before the test? **No Yes**
   If yes, what was the value?_____(should be < 15mmol/l)

3. Do you take any pain medications? These include Percocet, Percodan,
   Demerol, Tylox, Tylenol#3, oxycodone, Fentynal patch, Methadone and
   Others. **No Yes**
   If yes which one(s)?
   When did you last take this type of medicine?

4. Do you take any **medications that speed up your GI tract?** These include medications such as Reglan, Zelnorm, Domperidone and Erythromycin. **No Yes**
   If yes which ones(s)?
   When did you last take this medication?

5. Do you take any **GLP-1 Agonist medications**? These include Ozempic, Wegovy, Mounjaro, Rybelsus, Trulicity Zoenda and Victroza. **No Yes**
   If yes, which one?
   When did you take it last?

6. List any other medications you take:

7. Have you had any surgery on your GI tract- esophagus, stomach or colon? **No Yes**

   If yes please describe: