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GASTROINTESTINAL DISORDERS QUESTIONNAIRE (To be completed by the Medical Examiner)
KUESIONER GANGGUAN GASTROINTESTINAL *(Diisi oleh Pemeriksa Kesehatan)*

Proposal Number / *Nomor SPAJ* :_____

Name / *Nama Calon Tertanggung* :_____

New NRIC No / *Nomor Identitas Diri* :_____

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1. What was the diagnosis made? / *Apakah dignosanya?*

   _____

   _____

2. When was it first diagnosed? / *Kapan pertama kali terdiagnosa?*

   _____

   _____

3. Please give history of the symptoms or signs, their durations and whether they were mild, acute or chronic? / *Mohon berikan riwayat gejala-gejala atau tanda-tanda gangguan tersebut, waktunya dan kategorinya apakah Ringan, Akut atau kronis?*

Date / *Tanggal*	**Symptoms/Signs / *Gejala / Tanda-tanda***	**Duration / *Waktu***	**Mild, Acute and Chronic / *Ringan, akut dana kronis***

4. What were the contributing factors leading to the above disorder?
   Apakah faktor penyebab yang mengarah kepada masalah di atas?

   _____

   _____

5. What were the investigation (including diagnostic procedures) done? Please attach copies of results if available. / *Apa saja pemeriksaan yang telah dilakukan (termasuk tatacara diagnosanya)? Mohon lampirkan copy hasil pemeriksaan, jika ada.*

Date / Tanggal	**Test / Procedure / Tes / Tatacara**	**Results / Keputusan**

6. Was there any Helicobacter pylori detected / *Apakah ada ``Helicobacter pylori'' yang terdeteksi?*

   _____

   _____

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7. What was the treatment prescribed? / *Apakah jenis perawatan yang diberikan?*

   a) Conservative / *Biasa*

Date / *Tanggal*	Medication / *Obat-obatan*	Dosage / *Dosis*	Response /*Tindakan*

   b) Surgical / *Pembedahan*

Date / *Tanggal*	Surgical Performed / *Pembedahan yang dilakukan*	Post-operative results / *Hasil setelah Pembedahan*

8. Has there been any relapse or recurrence after treatment?
   Apakah gangguan tersebut pernah kambuh atau terjadi lagi setelah masa pembedahan?

   _____

   _____

9. Would a further surgical operations be required? If so, please state when?
   Apakah pembedahan/operasi lanjutan diperlukan? Jika "Ya", mohon jelaskan kapan?

   _____

   _____

10. Are there any evidence of malignancy?
    Apakah ada tanda-tanda pertumbuhan ?

    _____

    _____

11. Has he / she fully recovered? *Apakah Tertanggung telah sembuh sepenuhnya?*

    _____

    _____

Signature of Medical Examiner / : _____ Date / *Tanggal* : _____
Tandatangan Pemeriksa Kesehatan

Name / *Nama* : _____ Clinic Stamp / *Stempel klinik* : _____