THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Fecal Microbiota Transplantation Intake Questionnaire

Gastroenterology
Infectious Disease

913-588-1227
fmt@kumc.edu

MRN: _____

Patient name: _____ Date of birth: _____/_____/_____

Phone: _____ Alternate: _____ Email: _____

Original C. difficile diagnosis date: _____ Number of C. difficile infection episodes: _____

Has the patient been hospitalized for a C. difficile infection? Y or N

If yes, how many times? 1 2 3 4 5 5+

Approximate dates and reason for hospitalization: _____

Average number of stools in 24-hour period: _____

Check past treatments (indicate number of times tried, dose, duration of each treatment, including tapering regimen, if possible)

- ☐ Vancomycin _____
- ☐ Flagyl® (Metronidazole) _____
- ☐ Dificid® (Fidaxomycin) _____
- ☐ Xifaxan® (Rifaximin) _____
- ☐ Probiotics (give name) _____
- ☐ Other (give name) _____

Were any non-CDI antibiotics used prior to FMT? Y or N

If yes, list: _____

IBD History: Ulcerative colitis Indeterminate colitis Crohn's disease N/A

FMT indication: Recurrent or Severe

FMT was done: Inpatient or Outpatient

FMT was done through: Colonoscopy Capsules Enema Sigmoidoscopy

At the time of FMT, indicate values of

White blood cells: _____ Albumin: _____ Creatinine: _____

Other medical conditions/diagnoses: _____

Past surgeries: _____

Is this a repeat FMT? Y or N If yes, what number FMT is this? _____