Bowel Symptom Questionnaire

Name:          Date:

Doctor:

**Which symptoms best describe you? Select all that apply.**

- Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time
- Bowel accidents while unaware—no warning and/or while asleep
- Frequent, loose, watery stools
- Sudden or strong urge to go to the bathroom
- Bowel accidents when passing gas
- No bowel problems (if checked, please discontinue questionnaire)

**How long have you had these symptoms?**

**Approximately how many bowel incidents do you have per week?**

**Have you tried medications to help your symptoms?** Yes No

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

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<tbody>
<tr>
<td>No Relief</td>
<td>Complete Symptom Relief</td>
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**Behavior modifications tried?**

(e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

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<tr>
<td>Not Frustrated</td>
<td>Very Frustrated</td>
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**Are you interested in learning more about additional treatment alternatives to bowel medications?** Yes No