

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.

0	1	2	3	4	5	6	7	8	9	10
<i>No Relief</i>					<i>Complete Symptom Relief</i>					

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.

0	1	2	3	4	5	6	7	8	9	10
<i>Not Frustrated</i>					<i>Very Frustrated</i>					

Are you interested in learning more about additional treatment alternatives to bowel medications?

Yes No