BOWEL SYMPTOM QUESTIONNAIRE

WE REQUEST THAT YOU COMPLETE THIS QUESTIONNAIRE SO WE MAY BETTER ASSIST YOU IN YOUR CARE. OUR PRACTICE OFFERS SEVERAL SPECIALTIES THAT MAY BE A BENEFIT TO YOU. PLEASE ANSWER THE FOLLOWING QUESTIONS.

NAME: _____ DOB: _____

DOCTOR: _____ DATE: _____

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
- ☐ 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 medication 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 a number.

1	2	3	4	5	6	7	8	9	10

No Relief — *Complete Symptom Relief*

Behavior modification tried? (e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 1 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 numer.

1	2	3	4	5	6	7	8	9	10

Not Frustrated — *Very Frustrated*

Are you interested in learning about additional treatment alternatives to bowel medications? Yes No