Bowel Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe you? Check 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? Circle number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

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? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

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

UC201201780b EN