Medtronic

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

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? Select 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

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