NAME _____ DATE OF BIRTH _____ DATE _____

Being seen by Dr. _____ at Center for Colon & Rectal Health, Inc.

BOWEL CONTROL SATISFACTION SURVEY

____ N/A (Please read survey and check if not applicable)

Which symptoms best describe you:
____ Bowel accidents because I am unable to make it to the bathroom in time
____ Bowel accidents while asleep/unaware
____ Frequent loose, watery stools
____ No accidents - I always stay near a bathroom to prevent them
____ I am afraid to go out because I might have an accident

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

Approximately how many bowel accidents do you have per week **_____**

Behavior Modifications tried **_____**
(i.e. diet changes, fiber, lifestyle changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help your symptoms? Y / N
If Yes, check the medications you have tried:
____ Diphenoxylate ____ Lomotil®
____ Imodium® ____ Loperamide
____ Imotil® ____ Other _____

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief *Completely Cured*

If you have stopped taking your medications, explain why:
____ Did not help ____ Side effects ____ Too expensive
Describe side effects _____

What is the level of frustration with your bowel control symptoms. Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated *Very Frustrated*

I am interested in learning more about other treatment options Y / N