

BOWEL CONTROL SURVEY

Name _____ Age _____ Date _____

Which symptoms best describe you?

- Bowel accidents because I am unable to make it to the bathroom in time
- Frequent loose, watery stool
- Abdominal pain

How long have you had these symptoms? _____

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

Behavior modifications you have tried: _____
 (i.e., lifestyle changes, fiber, diet changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

- Imodium® Lomotil®
- Imotil® Diphenoxylate
- Loperamide 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've stopped taking your meds, explain why:

- Did not Help Side Effects Too Expensive

Describe Side Effects _____

What is your 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 treatment alternatives to medications:

- Yes No