Bowel Symptom Questionnaire

Name: _____

Date: _____

Provider Name: _____

The following questions only pertain to your bowel movements and bowel habits. This questionnaire is designed to assess for any fecal incontinence (unintentional bowel movements that you cannot control, soiling your clothes and undergarments, …..).

Please mark all that apply:

Do you have accidental bowel movements? _____

Do you leak stool before making it to the bathroom? _____

Do you have loose watery stools? _____

Do you have sudden or strong urges to go to the bathroom to have a bowel movement? _____

Do you have accidental bowel movements when you think you are just passing gas? _____

If you answered YES to any of the above symptoms, how long have you had this symptom? _____

How many times a week do you have accidents with your bowel movements?_ _____

Have you tried any medicine for diarrhea or constipation? _____

Have you tried any lifestyle changes, physical therapy, or diet changes for your accidental bowel movements? _____