AdventHealth Medical Group

Julie Schneider, MD, FACOG, FPMRS – Urogynecology

BOWEL CONTROL SURVEY

Name____ Dob __________________ Age______ Date _________________

☐ **I have read the information below and it does not apply to me. Signature:** ______________________________

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

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