

**BOWEL ASSESSMENT
PATIENT
QUESTIONNAIRE**

Patient Identification

Thank you for choosing UC San Diego Health System for your gastrointestinal motility needs. Please fill out this medical history form, as well as the "Home Medication List" section on the form entitled "Medication Reconciliation Ambulatory Care." **Please return both of these forms on the day of your appointment.**

Height: _____ Weight: _____ Referring Doctor: _____

Which problem(s) are you having: ☐ Constipation ☐ Diarrhea ☐ Bowel Control
☐ Other (please describe) _____

Do you have the following?	Yes	No
Constipation		
Diarrhea		
Trouble getting to the toilet on time		
Irritable Bowel Syndrome		
Spastic Colon		
Trouble controlling gas		
Abdominal pain		
If yes, where is your abdominal pain?		
Pain in the rectum		
Lower back pain		
If yes, describe your lower back pain		
How long have you had your pain?		
Please answer the following questions	Yes	No
Do you feel the urge to have a bowel movement?		
Can you tell if there is solid, liquid or gas in the rectum?		
Do you take a fiber substitute?		
If yes, which fiber substitute do you take?		
Do you exercise?		
If yes, what do you do and how often?		
How many bowel movements do you have per week?		
How many bowel movements do you have per week without laxatives?		
How many bowel movements do you have per week with laxatives?		



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How many bowel movements do you have per week with enemas?

What is the longest time you have gone without a bowel movement?

Do you experience any of the following bladder troubles?

- ☐ Excessive frequency ☐ Burning ☐ Spasms ☐ Trouble controlling urine
☐ Infections ☐ Leaking ☐ Prostate infections ☐ Enlarged prostate

Do you experience any of the following?

- ☐ Nausea ☐ Vomiting ☐ Bloating ☐ Indigestion
☐ Trouble Swallowing ☐ Loss of appetite ☐ Belching acid into mouth

List all previous surgeries and approximate dates: _____

List the previous tests you have had for your bowel problems, including dates and results:

If you have CONSTIPATION, please complete this section		
Please answer the following questions	Yes	No
Did you have constipation as a child?		
Did you have constipation as a teenager?		
Do you have relief with your menstrual period?		
Do you feel completely empty after having a bowel movement?		
How long have you had a problem with constipation?		
Do you have to strain to have a bowel movement? ☐ Yes ☐ No ☐ Sometimes		
How long do you sit on the toilet?		
If you use laxatives, what are you using and how often?		
If you use enemas, what are you using and how often?		
If you have DIARRHEA, please complete this section		
Please answer the following questions	Yes	No
Do you have diarrhea after eating?		
How long have you had diarrhea?		
How often do you have diarrhea?		



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If you have TROUBLE WITH BOWEL CONTROL, please complete this section		
Please answer the following questions	Yes	No
Did you have bowel control problems as a child?		
Did you have bowel control problems as a teenager?		
Do you sometimes have staining in your underwear?		
Do you feel completely empty after having a bowel movement?		
How long have you had trouble controlling your bowels?		
Indicate if you have problems controlling? ☐ Gas ☐ Liquid ☐ Solid		
How often do you have problems controlling your bowels?		
Indicate if you use: ☐ Pantiliner ☐ Sanitary Napkin ☐ Diaper		
WOMEN, please complete this section		
Please answer the following questions	Yes	No
Do you experience pain in the vagina?		
Do you experience vaginal spasms?		
Do you experience menstrual cramps?		
Please answer pregnancy and childbirth questions	Yes	No
Difficulties with labor and delivery?		
Difficulties with episiotomies or tearing?		
Any trouble with urine or bowel leaking after pregnancy?		
Did you have trouble with urine control during pregnancy?		
Number of pregnancies:		
Number of miscarriages:		
Number of deliveries:		
Number of vaginal deliveries:		
Number of C-Sections:		

Patient Signature

Date/Time