

**PATIENT ASSESSMENT QUESTIONNAIRE: BOWEL SYMPTOMS**

Updated Summer 2010

Please complete this questionnaire to the best of your ability as it relates to any bowel symptoms you might be experiencing. For each question below, please *circle the answer that best describes how you feel*. Then, **mark your score (0-4 points) for each answer in the column to the right**. When you are finished, **add up the numbers in that column for your total score**. Please return this form to the CEC office with your medical records and narrative for review and evaluation.

**Patient Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**I have been diagnosed with Endometriosis of the bowel:** yes no

**I have been diagnosed with IBS or other GI condition:** yes no

		0 points	1 point	2 points	3 points	4 points	Score
1.	How many times do you experience bowel movements during the day?	3-6	7-10	11-14	15-19	20+	
2.	A. How many times do you experience bowel movements at night?	0	1	2	3	4+	
	B. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderately	Severely		
3.	Are you currently sexually active? YES____ NO____						
4.	A. <b>If you are currently sexually active</b> , do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always		
	B. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always		
5.	Do you have pain associated with your bowel or in your pelvis (rectum, GI tract, etc.)?	Never	Occasionally	Usually	Always		
6.	Do you have blood in stool?	Never	Occasionally	Usually	Always		
7.	A. If you have pain with bowel movements, is it usually...		Mild	Moderate	Severe		
	B. Does your pain bother you?		Never	Occasionally	Usually	Always	
8.	A. If you have urgency to move your bowels, it is usually...		Mild	Moderate	Severe		
	B. Does your urgency bother you?	Never	Occasionally	Usually	Always		
<b>YOUR TOTAL SCORE:</b>							