BOWEL QUESTIONNAIRE

"Check all that apply"	YES	NO
*Less than three bowel movements per week:	☐	☐
Greater than three bowel movements a day:	☐	☐
*Hard/lumpy stool:	☐	☐
*Constipated:	☐	☐
Loose/watery stool:	☐	☐
Incontinent:	☐	☐
*Straining during bowel movement:	☐	☐
Urgency:		
- Constant:	☐	☐
- Intermittent:	☐	☐
*Incomplete emptying:	☐	☐
Passing mucus (white material) during bowel movement:	☐	☐
*Abdominal fullness, bloating, swelling:	☐	☐
*Can you control release of your gas?	☐	☐
*Do you pass gas during exertion?	☐	☐
*Pain either before or after bowel movement:	☐	☐
*History of hemorrhoids:	☐	☐
*Use of laxatives, stool softener:	☐	☐
If so, how many _____/day _____/wk.		

DIET (servings/day) (fruits, vegetables, protein, grains):

_____

CAFFEINE INTAKE (ounces per day)
(coffee, tea, soda, hot chocolate): _____

_____

WATER INTAKE (ounces per day): _____

Do you read/sit for long periods on the toilet? _____