Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

PATIENT QUESTIONNAIRE

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date: ____________________

1. What is your current bowel frequency?

(a) During the night Never ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ *(number?)*__________

(b) During the day Once ☐ 2-3 ☐ 4-5 ☐ 6+ ☐ *(number?)*__________

(c) Total number of motions per week ______________

2. What is the normal consistency of your stool?
- use the Bristol stool scale here

(Your answer may be a range)

____

Bristol Stool Chart

Type	Description
Type 1	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage-shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear-cut edges (passed easily)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. **Entirely Liquid**

3. How long have you been having your current symptoms?

____

4. These questions relate to difficulty in passing stools

(a) Do you strain when passing a stool more than 25% of the time? Yes ☐ No ☐

(b) Do you feel obstructed when trying to pass a stool more than 25% of the time?

Yes ☐ No ☐

(c) Do you have the sensation of incomplete evacuation more than 25% of the time?

Yes ☐ No ☐

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COLORECTAL PELVIC FLOOR CLINIC QUESTIONNAIRE

(d) Do you need to use your fingers to assist with passing stool more than 25% of the time?

Yes ☐ No ☐ *(if no, go to Q5)*

If yes, which of the following do you use?

(i) Rectal digitation Yes ☐ No ☐

(ii) Vaginal digitation Yes ☐ No ☐ N/A ☐

(iii) Perineal digitation Yes ☐ No ☐

(iv) Abdominal pressure Yes ☐ No ☐

5. Do you use pads? Yes ☐ No ☐ *(If no, go to Q6)*

Continuously: Yes ☐

No ☐ Day only ☐ Night only ☐

Why do you use pads?

Control of urinary leakage Yes ☐ No ☐

Control of bowel leakage Yes ☐ No ☐

If other reasons, please specify ______________________________

6. Do you get up at night to go to the toilet? Yes ☐ No ☐ *(If no, go to Q7)*

What for?

Bowels Yes ☐ No ☐

Urine Yes ☐ No ☐

Other (specify) ______________________________

7. Are you able to defer the passage of (hold on to) flatus (gas)? Yes ☐ No ☐

If yes, for how long? ______________________________

8. Are you able to defer passage of (hold on to) liquid stool? Yes ☐ No ☐

If yes, for how long? ______________________________

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9. Are you able to defer passage of (hold on to) solid stool? Yes ☐ No ☐

If yes, for how long?____

10. Do you ever soil yourself? Yes ☐ No ☐ *(If no, go to Q11)*

When running? Yes ☐ No ☐

When passing urine? Yes ☐ No ☐

During sex? Yes ☐ No ☐

When coughing? Yes ☐ No ☐

11. After going to the toilet do you need to return to the toilet shortly afterwards?

Yes ☐ No ☐ *(If no, go to Q12)*

What for?

Incomplete evacuation Yes ☐ No ☐

Leakage Yes ☐ No ☐

Hygiene Yes ☐ No ☐

Urine Yes ☐ No ☐

12. Do you have a sensation of prolapse? (feel like something has dropped down from its normal position?) Yes ☐ No ☐ *(If no, go to Q13)*

Where?

Anus Yes ☐ No ☐

Vagina Yes ☐ No ☐ N/A ☐

Bladder/Urethra Yes ☐ No ☐

13. Do you use enemas or suppositories to help with your problem? Yes ☐ No ☐

Details:____

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14. Do your symptoms vary with relation to food? Yes ☐ No ☐ *(If no, go to Q15)*

Dairy	Get better ☐	Get worse ☐
Spicy	Get better ☐	Get worse ☐
Caffeine	Get better ☐	Get worse ☐

Other foods? Specify____________ Symptoms: Better ☐ Worse ☐

____________ Symptoms: Better ☐ Worse ☐

____________ Symptoms: Better ☐ Worse ☐

15. Do your symptoms vary with physical activity? Yes ☐ No ☐ *(If no, go to Q16)*

If yes, are the symptoms: Better ☐ Worse ☐

16. Is there anything else that makes your symptoms better/worse?

Yes ☐ No ☐ *(If no, go to Q17)*

If yes,

Specify:______________________________ Symptoms: Better ☐ Worse ☐

Specify:______________________________ Symptoms: Better ☐ Worse ☐

17. How much does this problem affect your mobility?

Not at all ☐ Sometimes ☐ Most of the time ☐ Always ☐

18. If you go somewhere do you always know where the toilets are?

Yes ☐ No ☐

19. Do you delay leaving home due to this problem? Yes ☐ No ☐ *(If no, go to Q20)*

Details:____

20. Do you leak small amounts of mucus or stool after cleaning yourself?

Yes ☐ No ☐

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If you are male, please go to Q22

21. Ladies, what is your obstetric history?

(a) Number of pregnancies:________ Number of children:________

(b) Did you have any prolonged labours? Yes ☐ No ☐ Details:________hrs

(c) Size of largest baby?________

(d) Did you have any episiotomies (cuts) or tears? Yes ☐ No ☐

Degree of tear (if known)?________

22. Do you have any symptoms of urinary incontinence? Yes ☐ No ☐ *(If no, go to Q23)*

Urge Yes ☐ No ☐

Stress Yes ☐ No ☐

How often do you have these symptoms?

Sometimes ☐ Most of the time ☐ Always ☐

23. Have you had any previous anal surgery? Yes ☐ No ☐ *(If no, go to Q24)*

Fistulotomy (surgical opening of a fistula)	Yes ☐	No ☐
Haemorrhoidectomy	Yes ☐	No ☐
Dilatation (stretching)	Yes ☐	No ☐
Sphincter repair	Yes ☐	No ☐
Sphincterotomy (surgical cutting of the anal sphincter)	Yes ☐	No ☐

24. Have you had any previous abdominal surgery?

Yes ☐ No ☐ *(If no, go to Q25)*

Please specify:________

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25. Have you used any medications to help with your symptoms?

Yes ☐ No ☐ *(If no, go to Q26)*

Please specify:____

26. Have you made any dietary changes to help with the symptoms?

Yes ☐ No ☐ *(If no, go to Q27)*

Please specify:____

27. Do you have a history of spinal problems or surgery?

Yes ☐ No ☐ *(If no, go to Q28)*

Please specify:____

28. Do you have caffeine? Yes ☐ No ☐ Quantity:____________________

29. Do you drink alcohol? Yes ☐ No ☐ Quantity:____________________

30. Do you drink milk? Yes ☐ No ☐ Quantity:____________________

31. Do you have any other health problems/conditions? Yes ☐ No ☐

Please give details:____

____

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