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)
   ______________________

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 □
(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?______________________________________
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:  

Facility: QEII JUBILEE HOSPITAL
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 ☐  

11/14  QETH00001560.1
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:________________________________________
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:______________________________________