FECAL INCONTINENCE QUESTIONNAIRE

Name__________________________________ Date____________________

1. On average, how often did you pass a bowel movement in the past 3 months? (Please check one)
   o More than 3 times per day
   o 2 to 3 times per day
   o Once per day
   o 2 to 3 times per week
   o Less than once per week

2. What has been the usual consistency of your bowel movements in the past 3 months?
   (Please circle the ONE type that applies to you USUALLY)

Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Separate hard lumps, like nuts (hard to pass)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
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<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
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<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
</tr>
</tbody>
</table>
3. **Wexner Fecal Incontinence Score**: Please check the appropriate box in each row as honestly as possible regarding your bowel movement habits & your bowel control.

**Total Score (0-20): __________**

<table>
<thead>
<tr>
<th>Question</th>
<th>Never (0)</th>
<th>Less than once per month (1)</th>
<th>Less than once/ week &amp; greater than once/month (2)</th>
<th>Less than once/day &amp; greater than once/month (3)</th>
<th>Once a day or more than once a day (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have accidents to solid, well-formed stool?</td>
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<tr>
<td>How often do you have accidents to liquid stool/ diarrhea?</td>
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<tr>
<td>How often does the gas escape without your knowledge or control?</td>
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<tr>
<td>How often do you wear a pad/ depends or change underwear?</td>
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<tr>
<td>How much do the above answers alter your lifestyle or activities?</td>
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</tbody>
</table>

4. If you are NOT having full bowel accidents but you are having some **leakage of stool or gas**, please check the appropriate box in each row.

<table>
<thead>
<tr>
<th>Leakage</th>
<th>Never</th>
<th>1 to 3 times a month</th>
<th>Once a week</th>
<th>2 or more times a week</th>
<th>Once a day</th>
<th>2 or more times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Mucus</td>
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<tr>
<td>Liquid Stool</td>
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<tr>
<td>Solid Stool</td>
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</tr>
</tbody>
</table>
5. In the past month, did you have any warning or feeling when you needed to have a bowel movement?
   o Yes
   o No (If no, go to question 6)

If yes, did you have to rush/hurry to reach the toilet as soon as you felt the need to have a bowel movement?
   o Yes
   o No

6. In the past month, did you ever have bowel leakage shortly after emptying your bowels or passing a bowel movement?
   o Yes
   o No

7. In the past month have you experienced loss of control of your bladder:
   a) On coughing, laughing, sneezing or other physical activity?
      o Yes
      o No
   b) When feeling an urgent need to urinate, but not making it to the toilet on time?
      o Yes
      o No

8. The following questions are only for women.
   If you are a man, please go to question 11.
   a) How many children have you given birth to? ____________________
   b) How many were vaginal deliveries? ____________________
   c) In your longest labor, how long did you push for? ____________________
   d) Were forceps or instruments ever used? ____________________
   e) Did you ever have a tear or episiotomy involving the muscles of your anus? ____________________
   f) What was the weight of your largest baby? ____________________
   g) Have you ever had a hysterectomy, was it abdominal or vaginal, when was it done? ____________________

9. Have you ever had any of the following types of surgery to your bowels or anus?
   (Please check all that apply)
   o Removal and rejoining of part of your bowel
   o Anal fistula surgery
   o Operation on anal muscles
   o Operation on hemorrhoids or skin tags
   o Major prostate operation
   o Pelvic or prostate radiation
   o None of the above
10. Do you have a stoma for emptying your bowels?
   o Yes
   o No

11. Have you ever injured your anus (such as trauma, an accident, abuse), not including during labor?
   o Yes
   o No

12. Do you suffer from any of the following medical problems? (Please check all that apply)
   o Inflammatory bowel disease (Crohn’s disease or Ulcerative Colitis)
   o Irritable bowel syndrome
   o Rectal prolapse
   o Diabetes
   o Stroke
   o Other neurological condition
   o Decreased mobility
   o None of the above apply to me

13. During the past month, have you felt sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile?
   o Extremely so to the point where I have just about given up
   o Very much so
   o Quite a bit
   o Some so that it is enough to bother me
   o A little bit
   o Not at all

14. Have you every discussed loss of bowel control with anyone? (Please check all that apply)
   o No one
   o Family
   o Family doctor
   o Specialist
   o Other health professional, if so please state what kind of professional______________________

15. Have you been referred to any other services or physicians for loss of bowel control?
   o Yes, please state where____________________________________________________________
   o No

   THIS IS THE END OF YOUR QUESTIONNAIRE.

   THANK YOU FOR YOUR TIME & ASSISTANCE