

Cleveland Clinic Incontinence Score

Please tick one box in each row to indicate on average how often you experience the following:

	Never	Rarely Less than once a month	Sometimes Less than once a week	Usually Less than once a day	Always Everyday
a. Solid stool leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Liquid stool leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Gas leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Pad use (for stool)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lifestyle restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please fill in the dates of birth of your children and if the delivery was a Normal Vaginal Delivery or a Caesarean Section.

1 st Child	_ / _ / _ _ _ _	Delivery: _____
2 nd Child	_ / _ / _ _ _ _	Delivery: _____
3 rd Child	_ / _ / _ _ _ _	Delivery: _____
4 th Child	_ / _ / _ _ _ _	Delivery: _____
Other Children	_ / _ / _ _ _ _	Delivery: _____

Thank you very much for completing this questionnaire

Fecal Incontinence Quality of Life Instrument

Q 1: In general, would you say your health is:

- 1 Excellent
- 2 Very Good
- 3 Good
- 4 Fair
- 5 Poor

Q 2: For each of the items, please indicate how much of the time the issue is a concern for you due to accidental bowel leakage.

Q2. Due to accidental bowel leakage:	Most of the Time	Some of The Time	A Little of the Time	None of the Time
a. I am afraid to go out	1	2	3	4
b. I avoid visiting friends	1	2	3	4
c. I avoid staying overnight away from home	1	2	3	4
d. It is difficult for me to get out and do things like going to a movie or to church	1	2	3	4
e. I cut down on how much I eat before I go out	1	2	3	4
f. Whenever I am away from home, I try to stay near a restroom as much as possible	1	2	3	4
g. It is important to plan my schedule (daily activities) around my bowel pattern	1	2	3	4
h. I avoid traveling	1	2	3	4
i. I worry about not being able to get to the toilet in time	1	2	3	4
j. I feel I have no control over my bowels	1	2	3	4
k. I can't hold my bowel movement long enough to get to the bathroom	1	2	3	4
l. I leak stool without even knowing it	1	2	3	4
m. I try to prevent bowel accidents by staying very near a bathroom	1	2	3	4

Q 3: Due to accidental bowel leakage, indicate the extent to which you AGREE or DISAGREE with each of the following items.

Q3. Due to accidental bowel leakage:	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
a. I feel ashamed	1	2	3	4
b. I can not do many of things I want to do	1	2	3	4
c. I worry about bowel accidents	1	2	3	4
d. I feel depressed	1	2	3	4
e. I worry about others smelling stool on me	1	2	3	4
f. I feel like I am not a healthy person	1	2	3	4
g. I enjoy life less	1	2	3	4
h. I have sex less often than I would like to	1	2	3	4
i. I feel different from other people	1	2	3	4
j. The possibility of bowel accidents is always on my mind	1	2	3	4
k. I am afraid to have sex	1	2	3	4
l. I avoid traveling by plane or train	1	2	3	4
m. I avoid going out to eat	1	2	3	4
n. Whenever I go someplace new, I specifically locate where the bathrooms are	1	2	3	4

Q 4: During the past month, have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile?

- 1 Extremely So - To the point that I have just about given up
- 2 Very Much So
- 3 Quite a Bit
- 4 Some - Enough to bother me
- 5 A Little Bit
- 6 Not At All

PAC-SYM ©

PATIENT ASSESSMENT OF CONSTIPATION

This questionnaire asks you about your constipation symptoms in the **past 2 weeks**. Answer each question according to your symptoms, as accurately as possible. There are no right or wrong answers.

For each symptom below, please indicate **how severe** your symptoms have been during the **past 2 weeks**. If you have not had the symptom during the past 2 weeks, tick 0. If the symptom seemed mild, tick 1. If the symptom seemed moderate, tick 2. If the symptom seemed severe, tick 3. If the symptom seemed very severe, tick 4. Please be sure to answer every question.

How severe have each of these symptoms been in the past 2 weeks?	Absent 0	Mild 1	Moderate 2	Severe 3	Very severe 4
1. discomfort in your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. pain in your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. bloating in your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. stomach cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. painful bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. rectal burning during or after a bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. rectal bleeding or tearing during or after a bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. incomplete bowel movement, as though you didn't "finish"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. stools that were too hard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. stools that were too small	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. straining or squeezing to try to pass stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. feeling like you had to pass a stool but you couldn't (false alarm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAC-QOL ©

PATIENT ASSESSMENT OF CONSTIPATION ©

The following questions are designed to measure the impact constipation has had on your daily life **during the past 2 weeks**. For each question, please tick one box.

The following questions ask you about the <u>intensity</u> of your symptoms. To what extent, during the past 2 weeks...	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
1. have you felt bloated to the point of bursting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. have you felt heavy because of your constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions ask you about the effects of constipation on your <u>daily life</u>. How much of the time, during the past 2 weeks...	None of the time 0	A little of the time 1	Some of the time 2	Most of the time 3	All of the time 4
3. have you felt any physical discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. have you felt the need to open your bowel but not been able to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. have you been embarrassed to be with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. have you been eating less and less because of not being able to have bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions ask you about the effects of constipation on your <u>daily life</u>. To what extent, during the past 2 weeks...	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
7. have you had to be careful about what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. have you had a decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. have you been worried about not being able to choose what you eat (for example, at friend's)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. have you been embarrassed about staying in the toilet for so long when you were away from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. have you been embarrassed about having to go to the toilet so often when you were away from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. have you been worried about having to change your daily routine (for example, travelling, being away from home)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions ask you about your <u>feelings</u>. How much of the time, during the past 2 weeks...	None of the time 0	A little of the time 1	Some of the time 2	Most of the time 3	All of the time 4
13. have you felt irritable because of your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. have you been upset by your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. have you felt obsessed by your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. have you felt stressed by your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. have you been less self-confident because of your condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. have you felt in control of your situation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions ask you about your feelings. To what extent, during the past 2 weeks...	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
19. have you been worried about not knowing when you are going to be able to open your bowels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. have you been worried about not being able to open your bowels when you needed to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. have you been more and more bothered by not being able to open your bowels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions ask about your life with constipation. How much of the time, during the past 2 weeks...	None of the time 0	A little of the time 1	Some of the time 2	Most of the time 3	All of the time 4
22. have you been afraid that your condition will get worse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. have you felt that your body was not working properly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. have you had fewer bowel movements than you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next questions ask you about how satisfied you are. To what extent, during the past 2 weeks...	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
25. have you been satisfied with how often you open your bowels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. have you been satisfied with the regularity with which you open your bowels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. have you been satisfied with your bowel function?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. have you been satisfied with your treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IBS Module		
1. In the last 3 months, how often did you have discomfort or pain anywhere in your abdomen?	⓪ Never → ① Less than one day a month ② One day a month ③ Two to three days a month ④ One day a week ⑤ More than one day a week ⑥ Every day	<i>Skip remaining questions</i>
2. For women: Did this discomfort or pain occur only during your menstrual bleeding and not at other times?	⓪ No ① Yes ② Does not apply because I have had the change in life (menopause) or I am a male	
3. Have you had this discomfort or pain 6 months or longer?	⓪ No ① Yes	
4. How often did this discomfort or pain get better or stop after you had a bowel movement?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	
5. When this discomfort or pain started, did you have more frequent bowel movements?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	
6. When this discomfort or pain started, did you have less frequent bowel movements?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	
7. When this discomfort or pain started, were your stools (bowel movements) looser?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	
8. When this discomfort or pain started, how often did you have harder stools?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	
9. In the last 3 months, how often did you have hard or lumpy stools?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	Alternative scale: ⓪ Never or rarely ① About 25% of the time ② About 50% of the time ③ About 75% of the time ④ Always, 100% of the time
10. In the last 3 months, how often did you have loose, mushy or watery stools?	⓪ Never or rarely ① Sometimes ② Often ③ Most of the time ④ Always	Alternative scale: ⓪ Never or rarely ① About 25% of the time ② About 50% of the time ③ About 75% of the time ④ Always, 100% of the time