



We take your health seriously and will be using the information you provide here to help us understand your problems and take better care of you.

About You

Appointment Date: _____

Your Name: _____

Date of Birth (mm/dd/yyyy): _____

Street Address: _____

Age: _____

City: _____

Home Phone: _____

State: _____

Work Phone: _____

Zip: _____

Cell Phone: _____

1. What is your marital status? (*Check one*)

Married

Separated

Divorced

Never married

Widowed

Long-term partner

2. What is your occupation? If you are retired, what activities occupy most of your time? _____

3. Do your free time activities or your occupation require: (*Check all that apply*)

Sitting

Standing

Lifting

Pushing/pulling

4. How did you hear about us/who referred you to us?

TV

Web site

Friend

Brochure

Medical provider, (name): _____

Other: _____

5. Who is your primary care provider? _____

Why are you here today?

6. For what condition(s) are you seeking treatment? (*Check all that apply*)

If **yes**, how long have you had this symptom?

No	Yes	Symptom	Less than a year	1-2 years	3-5 years	More than 5 years
<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence (problem with bladder control)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Anal incontinence (problem with bowel control)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic prolapse (bulge or protrusion in the vagina)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Too frequent voiding/urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you need more space to describe your reasons for seeking treatment, please use the back of this page.

7. What would you be willing to do to improve your condition? (*Check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Lose weight | <input type="checkbox"/> Take medication |
| <input type="checkbox"/> Stop smoking | <input type="checkbox"/> Have surgery |
| <input type="checkbox"/> Physical therapy/exercise for the pelvic floor muscles | <input type="checkbox"/> Conservative management (combination of treatments to specifically avoid surgery) |
| <input type="checkbox"/> Diet/lifestyle modification | |

8. What have you done *in the past* to improve your symptoms? _____

9. What are your goals for treatment? (*Check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> To not leak urine | <input type="checkbox"/> To be normally active |
| <input type="checkbox"/> To improve bladder or bowel function | |
| <input type="checkbox"/> Other (specify): _____ | |

10. How *motivated* are you to take part in treatment or therapy?

- | | | | |
|-------------------------------------|-----------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Somewhat | <input type="checkbox"/> Very | <input type="checkbox"/> Extremely |
|-------------------------------------|-----------------------------------|-------------------------------|------------------------------------|

11. In general, would you say that your health is:

- | | | | | |
|-------------------------------|-------------------------------|-------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Poor | <input type="checkbox"/> Fair | <input type="checkbox"/> Good | <input type="checkbox"/> Very Good | <input type="checkbox"/> Excellent |
|-------------------------------|-------------------------------|-------------------------------|------------------------------------|------------------------------------|

12. What is your current activity level?

- | | | | |
|------------------------------------|--------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Sedentary | <input type="checkbox"/> Light | <input type="checkbox"/> Moderate | <input type="checkbox"/> Heavy |
|------------------------------------|--------------------------------|-----------------------------------|--------------------------------|

Menstruation

Answer questions 13-15 ONLY IF you are STILL menstruating.

13. When was your last menstrual period? _____
14. Is there any possibility you could be pregnant? No Yes
15. What type of birth control do you and your partner use? _____

Answer questions 16 & 17 ONLY IF you are NO LONGER menstruating.

16. Are you going through or have you gone through menopause? No Yes
17. Are you currently using hormones? No Yes

Birth

Answer questions 18-21 ONLY IF you HAVE given birth.

18. How many children have you given birth to? Vaginal: _____ Cesarean Section: _____
19. Did any of your children weigh 8 pounds or more? No Yes
20. Did you have any of the following? (*Check all that apply*)
- Severe tearing/cutting or episiotomy Forceps delivery Vacuum delivery
21. Did you have problems with incontinence within the first few weeks after delivery?
- Urinary Incontinence No Yes Don't know/remember
- Stool Incontinence No Yes Don't know/remember

Medical History

22. Have you had any of the following?
- Heart surgery Colon surgery Ovaries removed
- Kidney surgery Vascular surgery Pelvic physical therapy
- Radiation therapy to abdomen/pelvis for treatment of cancer
- Please list all other surgeries: _____
23. Have you had a hysterectomy? No Yes
- If yes,** was the incision Abdominal Vaginal Laparoscopic/robotic Don't know
24. Have you had bladder surgery? No Yes
- If yes,** was the incision Abdominal Vaginal Laparoscopic/robotic Don't know
- If yes,** was mesh used? No Yes Don't know
25. Have you had prolapse surgery? No Yes
- If yes,** was the incision Abdominal Vaginal Laparoscopic/robotic Don't know
- If yes,** was mesh used? No Yes Don't know
26. Have you had rectal surgery? No Yes
- If yes,** was the incision Abdominal Vaginal Laparoscopic/robotic Anal Don't know
- If yes,** was mesh used? No Yes Don't know

27. Check any of the following medical conditions that you currently have or have had in the past:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures | <input type="checkbox"/> Back Injury |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Clots
(not menstrual) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes With End
Organ Failure | Cancer Type/Location:
_____ | <input type="checkbox"/> Bleeding/Bleeding
Problems | Type of Glaucoma:
_____ |
| <input type="checkbox"/> Congestive Heart
Failure | <input type="checkbox"/> Kidney Disease
(moderate to severe) | <input type="checkbox"/> Peripheral Vascular
Disease | <input type="checkbox"/> Connective Tissue
Disease |
| <input type="checkbox"/> Hypertension (High
Blood Pressure) | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Intestinal Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | |

Is there is anything you would like us to know about one of these conditions? Do you have, or have you had, a condition not listed above? Please tell us about it on the back of this page.

Medications

28. Do you take any of the following medications?

	No	Yes	Dose	Frequency
Amitriptyline	<input type="checkbox"/>	<input type="checkbox"/>		
Detrol	<input type="checkbox"/>	<input type="checkbox"/>		
Ditropan	<input type="checkbox"/>	<input type="checkbox"/>		
Oxytrol/ Gelnique	<input type="checkbox"/>	<input type="checkbox"/>		
Sanctura	<input type="checkbox"/>	<input type="checkbox"/>		
Vesicare	<input type="checkbox"/>	<input type="checkbox"/>		
Enabelex	<input type="checkbox"/>	<input type="checkbox"/>		
Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>		
Fiber, (Metamucil , Citrucel, FiberCon, Psyllium, Fiberall, Hydrocil, Konsil, Benefiber, Other)	<input type="checkbox"/>	<input type="checkbox"/>		
Colace	<input type="checkbox"/>	<input type="checkbox"/>		
Laxatives, (Senokot, Ex-Lax, Correctal, MiraLax, Other)	<input type="checkbox"/>	<input type="checkbox"/>		

List all of your other medications. If you run out of room, please continue on the back or attach page.

Medication	Dose	Frequency	Medication	Dose	Frequency

29. Do you have any allergies to medications? No Yes

If yes, what are they? _____

30. Do you have any **allergies** to the following? (Check all that apply)

- Latex Tape Iodine/contrast

31. Do you have a **family history** of any of the following diseases? (*Check all that apply*)
- High blood pressure Heart disease Diabetes
- Problems similar to what you are being seen for at this visit
- Cancer (indicate type): Breast Colon Ovarian Bladder/Kidney Other cancer
- Other disease: _____
32. Do you smoke cigarettes? No Yes
- If **YES**, how many packs a day do you smoke? Less than 1 1-2 packs Greater than 2
- If **NO**, did you used to smoke? No Yes
- If **YES**, how long ago did you used to smoke? _____
33. Do you currently drink caffeinated beverages? No Yes
(coffee, tea, soda, energy drinks, etc.)
- If **YES**, how many cups per day? _____
34. During the last 30 days, have you had at least one drink of ANY kind of alcoholic beverages (including beer, wine or mixed drinks)? No Yes
- If **YES**, which statement comes closest to describing how often you drank any alcoholic beverage in the last 30 days?
- Every day 1-2 days per week
- 5-6 days per week 2-3 times in the last 30 days
- 3-4 days per week Once in the last 30 days
35. Recently (in the past few weeks) have you been bothered by: (*Circle all that apply*)
- General:..... Excessive weight gain / Weight loss / Fever / Chills
- Endocrine:..... Cold intolerance / Excessive thirst
- Eyes, Ears, Nose & Throat:..... Visual changes / Hearing loss / Headaches
- Respiratory:..... Coughing / Wheezing / Shortness of breath
- Cardiovascular:..... Chest Pain / Irregular heart rate / Swelling in legs
- Breast:..... Breast pain / Lumps / Nipple discharge
- Skin:..... Skin changes or rashes
- Gastrointestinal:..... Nausea / Vomiting / Difficulty swallowing / Diarrhea
- Musculoskeletal:..... Joint pain / Joint swelling / Muscle cramps
- Psychological:..... Depression / Anxiety / Mood changes
- Hematology:..... Easy bruising / Excessive bleeding / Night sweats
- Neurological:..... Dizziness / Weakness / Tingling sensations / Slurred speech
36. Now thinking about your mental health, which includes stress, depression and problems with emotions, how many **DAYS** during the past 30 DAYS (the last month) _____ **Days** was your mental health **NOT** good? (Your answer should be between 0-30 days.)

Your Symptoms

37. How many times per day do you urinate? _____
38. How many times do you wake up at night to urinate? _____
39. Do you ever wake up with urine on clothes/bed?
40. Do you have difficulty starting urination? No Yes
41. Do you have to strain to urinate? No Yes
42. Is your urine flow weak? No Yes
43. Do you leak *immediately* after emptying your bladder (when you walk away from the toilet)? No Yes
44. Do you ever see blood in your urine? No Yes
45. Do you get frequent bladder infections? No Yes
46. How often do you experience urinary leakage?
 Less than once a month A few times a month
 A few times a week Every day and/or night
47. How much urine do you lose each time?
 Drops Small splashes More
48. How many pads per day do you use for leakage protection? _____ pads/day
49. How many bowel movements do you have? _____ per day _____ per week
50. Have you ever seen blood in your stool? No Yes

Tools

The next pages contain special sets of questions that can help us to better understand your condition. Each set of questions has been scientifically tested and accurately measures a specific medical condition that we frequently see. Not all of the questions will apply to you. These sets of questions must be asked the same way each time to be valid. Some of the tools overlap slightly, so the questions may seem repetitive. They will help us provide you with the best quality of care and will help us measure your treatment outcomes. They will also help us improve the quality of care we provide.

We would like to know if you have certain bowel, bladder or pelvic symptoms. If you do, we'd also like to know how much they bother you.

- Please answer **all** of the questions in the following survey.
- Answer by filling the appropriate circle or circles.
- When answering, please consider your symptoms **over the last 3 months**.

If yes, how much does this bother you?

Do you...		No	Yes	Not at all	Some-what	Moderately	Quite A bit
1.	Usually experience <i>pressure</i> in the lower abdomen?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Usually experience <i>heaviness</i> or <i>dullness</i> in the pelvic area?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Usually have a bulge or something falling out that you can see or feel in the vaginal area?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Usually have to push on the vagina or around the rectum to have or complete a bowel movement?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Usually experience a feeling of incomplete bladder emptying?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Ever have to push up on a bulge in the vaginal area with your fingers to start or complete urination?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Feel you need to strain too hard to have a bowel movement?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Feel you have not completely emptied your bowels at the end of a bowel movement?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Usually lose stool beyond your control if your stool is well formed?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Usually lose stool beyond your control if your stool is loose?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Usually lose gas from the rectum beyond your control?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Usually have pain when you pass your stool?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does part of your bowel ever pass through the rectum and bulge outside during or after a bowel movement?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Usually experience frequent urination?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Usually experience urine leakage associated with a feeling of urgency; that is, a strong sensation of needing to go to the bathroom?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued on next page

Do you...		If yes, how much does this bother you?					
		No	Yes	Not at all	Some-what	Moder-ately	Quite A bit
17.	Usually experience urine leakage related to coughing, sneezing or laughing?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Usually experience small amounts of urine leakage (that is, drops)?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Usually experience difficulty emptying your bladder?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Usually experience <i>pain</i> or <i>discomfort</i> in the lower abdomen or genital region?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	If you answered YES to question 20, then is your pain relieved after emptying your bladder?				<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Your Activities

Some women find that bladder, bowel or vaginal symptoms affect their activities, relationships and feelings. For each question, mark the box that best describes how much your activities, relationships or feelings have been affected by your bladder, bowel or vaginal symptoms **over the last 3 months**.

Please make sure to answer all 3 columns for each question.

How do symptoms or conditions related to the following → usually affect your:	Bladder or Urine	Bowel or Rectum	Vagina or Pelvis
1. Ability to do household chores (cooking, housecleaning, laundry)?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
2. Ability to do physical activities such as walking, swimming or other exercise?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
3. Entertainment activities such as going to a movie or concert?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit
4. Ability to travel by car or bus for a distance greater than 30 minutes away from home?	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit	<input type="checkbox"/> Not at all <input type="checkbox"/> Somewhat <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit

	Never	Seldom	Some- times	Usually	Always
6. Do you feel pain during sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you incontinent of urine (leak urine) with sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does fear of incontinence (either stool or urine) restrict your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you avoid sexual intercourse because of bulging in the vagina (either the bladder, rectum or vagina falling out)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. When you have sex with your partner, do you have negative emotional reactions such as fear, disgust, shame or guilt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your partner have a problem with <u>erections</u> that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does your partner have a problem with premature ejaculation that affects your sexual activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Much less intense	Less intense	Same intensity	More intense	Much more intense
13. Compared to orgasms you have had in the past, how intense are the orgasms you have had in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever been raped or forced to engage in sexual activity against your will?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
15. Have you been hit, punched or otherwise hurt by someone within the past year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
16. Do you feel unsafe in your current relationship?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
17. Is there a partner from a previous relationship who is making you feel unsafe now?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
18. Is there anything you would like to add? (If you run out of room, please continue on the back.) _____					

Bowel Symptoms

Please complete this questionnaire if you have any trouble controlling gas or bowel movements. If you **DO NOT**, then you are finished completing this questionnaire. Thank you for taking the time to do so. We greatly appreciate your efforts.

For each of the following, please indicate, on average, how often in the past month you experienced any amount of accidental bowel leakage: *(Check only one box per row)*

		2 or More Times a Day	Once a Day	2 or More Times a Week	Once a week	1 to 3 Times a Month	Never
1.	Gas						
2.	Mucus						
3.	Liquid Stool						
4.	Solid Stool						

For each of the following items, please indicate how much of the time the issue is a concern for you due to accidental bowel leakage. (If it is a concern for you for reasons other than accidental bowel leakage then check the box under Not Apply, (N/A).)

5. In general, would you say that your health is:
 Poor Fair Good Very Good Excellent

	Due to accidental bowel leakage:	Most of the time	Some of the time	A Little of the Time	None of the time	N / A
6.	I am afraid to go out					
7.	I avoid visiting friends					
8.	I avoid staying overnight away from home					
9.	It is difficult for me to get out and do things like going to a movie or to church					
10.	I cut down on how much I eat before I go out					
11.	Whenever I am away from home, I try to stay near a restroom as much as possible					
12.	It is important to plan my schedule (daily activities) around my bowel pattern					
13.	I avoid traveling					
14.	I worry about not being able to get to the toilet in time					
15.	I feel I have no control over my bowels					
16.	I can't hold my bowel movement long enough to get to the bathroom					
17.	I leak stool without even knowing it					
18.	I try to prevent bowel accidents by staying very near a bathroom					

Due to accidental bowel leakage, indicate the extent to which you **AGREE** or **DISAGREE** with each of the following items. (If it is a concern for you for reasons other than accidental bowel leakage, check the box under Not Apply, (N/A).)

Due to accidental bowel leakage:	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	N/A
19. I feel ashamed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I cannot do many of the things I want to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I worry about bowel accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I feel depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I worry about others smelling stool on me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I feel like I am not a healthy person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I enjoy life less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I have sex less often than I would like to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I feel different from other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. The possibility of bowel accidents is always on my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I am afraid to have sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I avoid traveling by plane or train	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I avoid going out to eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Whenever I go someplace new, I specifically locate where the bathrooms are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- Extremely so, to the point that I have just about given up
- Very much so
- Quite a bit
- Some, enough to bother me
- A little bit
- Not at all

Thank you very much for completing this questionnaire. It will help us take better care of you.