# Patient Gastrointestinal Health Survey

Name: _____ Date: _____

Physician Name *(if known)*: _____

We want to be sure that we offer you the highest level of service and medical care. Help us by completing this brief, confidential survey.

**Please circle your response**

| | | | | | |
|---|---|---|---|---|---|
| 1) | Do you suffer from constipation? | | | Yes | No Unsure |
| 2) | Do you experience infrequent, hard, or difficult-to-pass bowel movements? | Always | Often | Sometimes | Rarely |
| 3) | How many bowel movements do you have per week (fill in the blank)? | | | _____ | |
| 4) | Do you suffer from fecal incontinence? | | | Yes | No Unsure |
| 5) | Do you experience bowel leakage/staining? | | | Yes | No Unsure |
| 6) | Do you experience pain during bowel movements? | | | Yes | No Unsure |
| | a. If so, with what frequency? | Always | Often | Sometimes | Rarely |
| 7) | Have you experienced chronic, excessive flatulence (gas)? | | | Yes | No Unsure |
| 8) | Do you experience bleeding during bowel movements? | | | Yes | No Unsure |
| | a. If so, with what frequency? | Always | Often | Sometimes | Rarely |
| 9) | Do you experience pain in your lower abdomen, rectum, or anus when you are **not** passing a bowel movement? | | | Yes | No Unsure |
| | a. If so, with what frequency? | Always | Often | Sometimes | Rarely |
| 10) | Have you been diagnosed with Irritable Bowel Syndrome (IBS)? | | | Yes | No Unsure |
| 11) | Have you ever received pelvic floor therapy? | | | Yes | No Unsure |

**Thank you!**