Cornwall Partnership NHS
NHS Foundation Trust

SELF-ASSESSMENT OF YOUR BOWEL PROBLEMS

To help us to help you improve the bowel problems you are experiencing, it is important that you complete as much of the form as possible. This will assist the nurse to identify your particular problem.
Please take your time and feel free to contact your nurse if you have any concerns or worries about the form. The details will be treated in the strictest confidential manner.

Date Completed: NHS No:	Surname: Forename:
Male / Female *(please circle)*	Date of Birth:
Address: Postcode: Preferred contact number:	GP:
How long have you had bowel problems?	
Have you sought help or advice before? YES / NO *(circle)*	
If **YES** from whom, and when did you seek advice?	

How does your bowel problem affect your quality of life?

Please tick	Not at all	A little	Moderately	A lot
	☐	☐	☐	☐

Your medical history:	Please list any operations/serious illnesses that you have had or currently have:
Your current medications *(include over the counter medications):*	
Are you bothered by your bladder habits? *(if so, how)*	

Mobility / Dexterity (please tick which ones apply to you)

1) Able to get around easily without any help
2) Can only get around with help
3) Able to get on and off the toilet easily
4) Do you have /need a carer?
5) Able to dress and undress myself
6) Anything else? If so, please describe

……..
……
….

Approximate height:	Approximate weight:
Do you smoke? (please circle) YES NO	If yes: What do you smoke? How many do you smoke?

Fluid intake:

How many mugs / cups do you drink each day?
What type of fluid is it? ……

What makes the problem worse? ……

What makes the problem better? …….

Can you think of any particular event that caused the onset of these problems? ……

If yes, briefly describe what happened? ……
……
What do you feel is the worst part of your complaint? ……
……..
……..
……..

Do you have any allergies? (If so, what are they) ……..

If you have given birth, did you have any difficulty? (please circle)
YES NO

Clinicians use only

Patient name: *NHS No:*

Do you suffer from any of the following complaints?

Spinal problems	Multiple Sclerosis	Anal fissures/hemorrhoids
Irritable bowel disease	Diabetes	Anal Abscesses
Heart Problems	Hypothyroidism	Crohns Disease
Depression	Rectocele	Ulcerative colitis
Rectal bleeding	Unintentional weight loss	

Can you hold flatus (wind)?	Yes	No
Do you leak loose stool?	Yes	No
Do you leak normal stool?	Yes	No
Do you soil when you pass flatus (wind)?	Yes	No
Can you tell the difference between stool and wind when it is in your back passage?	Yes	No
Do you feel you can empty your bowels completely?	Yes	No
Do you ever have the feeling that the stool sticks in your back passage?	Yes	No

Do you ever need to manually assist to move your bowel?		Yes	No
If Yes: Do you need to assist digitally by pressing: (Please circle which)	Inside of your vagina	Inside your anus (bottom)	On the Perineum (the area between vagina/penis & anus)

Please tick the most appropriate response to the following questions:

		ALWAYS	DAILY	WEEKLY	MONTHLY	RARELY	NEVER
1	Do you ever strain to empty your bowel?						
2	Do you ever feel you have not emptied your bowel completely?						
3	Do you ever need to rush to empty your bowel?						
4	Do you ever feel that the lining of your bottom comes down?						

To question 4, is this at the toilet or on walking? ……

Clinicians use only

Patient Name: *NHS No:*

		ALWAYS	DAILY	WEEKLY	MONTHLY	RARELY	NEVER
5	Do you have difficulty wiping? (need to use a lot of paper after a bowel movement)						
6	Do you leak/soil soon after a bowel movement?						
7	Do you pass mucous from your back passage?						

For each of the following, please indicate on average <u>how often in the past month</u> have you experienced any amount of accidental bowel leakage.

	2 or more times day (please state)	**Once a day**	**2 or more times a week**	**Once a week**	**1-3 times month**	**Rarely**	**Never**
Wind leakage							
Mucous leakage							
Liquid stool leakage							
Solid stool leakage							
Leakage during the night							

If you get any leakage is this (please tick):

a minor stain	**a small amount**	**a moderate amount**	**a large amount**	**variable**
☐	☐	☐	☐	☐

Please answer the following questions in relation to your current URINARY (water works symptoms).

	EVERY TIME	**DAILY**	**WEEKLY**	**MONTHLY**	**RARELY**	**NEVER**
Do you ever rush to pass urine?						
Do you ever leak urine if you cough, sneeze etc.						
Do you ever not make it in time to pass urine?						

	ALWAYS	**USUALLY**	**SOME TIMES**	**NEVER**	**TYPE OF PAD**	**HOW MANY IN 24 HRS**
Do you wear a pad for any **URINARY** problems?						
Do you wear a pad for your **BOWEL** problem?						
Do your **bowel/urinary symptoms** affect: Your lifestyle Your sexual relationships Your work Your social life *Please underline which applies*						

Please comment, if you wish, in the space provided:

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Patient Name: *NHS No:*

Stool chart

This chart is designed to give the doctors /nurses a good idea of your bowel habits. Please fill in the chart every day for 14 days (referring to the Bristol Stool Form Scale).

Date	**Time**	**Type of stool** (use number from Bristol stool chart)	**Quantity of Stool** • Large • Medium • Small • None	**Pain and distress when passing stool** • Yes • Some • No	**Soiling** Yes or No?	**Dose of laxative taken:**			
						Breakfast	Lunch	Dinner	Night

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Patient Name: *NHS No:*

Food and fluid chart

Day of the week :		Date :	
All food that you eat		All fluids that you drink	
Time		Time	
Day of the week :		Date :	
All food that you eat		All fluids that you drink	
Time		Time	
Day of the week :		Date :	
All food that you eat		All fluids that you drink	
Time		Time	
Day of the week :		Date :	
All food that you eat		All fluids that you drink	
Time		Time	
Day of the week :		Date :	
All food that you eat		All fluids that you drink	
Time		Time	

Clinicians use only

Patient Name: *NHS No:*