

Initial number

ICIQ-B (04/08)

CONFIDENTIAL

DAY MONTH YEAR

Today's date

Many people experience bowel accidents or bowel leakages. We are trying to find out how many people experience these symptoms and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been over the PAST THREE MONTHS.

1 Please write in your date of birth:

DAY MONTH YEAR

2 Are you (tick one):

Female Male

Bowel pattern

3 On average how many times do you open your bowels in 24 hours?

(Tick one box for 'usual' and tick one box for 'at worst')

	(a) Usual	(b) At worst
less than once	<input type="checkbox"/> ¹	<input type="checkbox"/> ¹
one to three times	<input type="checkbox"/> ²	<input type="checkbox"/> ²
<u>three to ten times</u>	<input type="checkbox"/> ³	<input type="checkbox"/> ³
<u>ten or more times</u>	<input type="checkbox"/> ⁴	<input type="checkbox"/> ⁴

(c) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

4 How often do you open your bowels during the night from going to bed to sleep until you get up in the morning? (Tick one box)

	(a)
never	<input type="checkbox"/> ⁰
once	<input type="checkbox"/> ¹
<u>twice</u>	<input type="checkbox"/> ²
<u>three times</u>	<input type="checkbox"/> ³
<u>four or more times</u>	<input type="checkbox"/> ⁴

(b) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

5 Do you have to rush to the toilet when you need to open your bowels?
(Tick one box)

- (a) never 0
- rarely 1
- some of the time 2
- most of the time 3
- always 4

(b) **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

6 Do you use medications (tablets or liquids) to stop you opening your bowels?
(Tick one box)

- (a) never 0
- less than once a month 1
- less than once a week 2
- less than once a day 3
- about once a day 4
- several times a day 5

(b) **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

7 Do you experience pain/soreness around your back passage? (Tick one box)

- (a) never 0
- rarely 1
- some of the time 2
- most of the time 3
- always 4

(b) **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

Bowel pattern score: sum scores 3a - 7a

Bowel control

8 Do you experience any staining of your underwear or need to wear pads because of your bowels? (Tick one box)

- (a)
- never 0
- less than once a month 1
- less than once a week 2
- less than once a day 3
- everyday 4

(b) **How much does this bother you?**

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

9 Are you able to control watery or loose stool leaking from your back passage? (Tick one box)

- (a)
- always 0
- most of the time 1
- some of the time 2
- rarely 3
- never 4

(b) **How much does this bother you?**

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

10 Are you able to control accidental loss of formed or solid stool from your back passage? (Tick one box)

- (a)
- always 0
- most of the time 1
- some of the time 2
- rarely 3
- never 4

(b) **How much does this bother you?**

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

11 Are you able to control wind (flatus) escaping from your back passage?

(Tick one box)

(a)	
always	<input type="checkbox"/> 0
most of the time	<input type="checkbox"/> 1
<u>some of the time</u>	<input type="checkbox"/> 2
<u>rarely</u>	<input type="checkbox"/> 3
<u>never</u>	<input type="checkbox"/> 4

(b) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
not at all										a great deal

12 Are you able to control mucus (discharge) leaking from your back passage?

(Tick one box)

(a)	
always	<input type="checkbox"/> 0
<u>most of the time</u>	<input type="checkbox"/> 1
<u>some of the time</u>	<input type="checkbox"/> 2
<u>rarely</u>	<input type="checkbox"/> 3
<u>never</u>	<input type="checkbox"/> 4

(b) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
not at all										a great deal

13 Do you have bowel accidents when you have no need to open your bowels?

(Tick one box)

(a)	
never	<input type="checkbox"/> 0
<u>rarely</u>	<input type="checkbox"/> 1
<u>some of the time</u>	<input type="checkbox"/> 2
<u>most of the time</u>	<input type="checkbox"/> 3
<u>always</u>	<input type="checkbox"/> 4

(b) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
not at all										a great deal

14 Are your bowel accidents or leakages unpredictable? (Tick one box)

(a)
never 0

rarely 1

some of the time 2

most of the time 3

always 4

(b) How much does this bother you?


Please ring a number between 0 (not at all) and 10 (a great deal)


0 1 2 3 4 5 6 7 8 9 10
not at all a great deal


Bowel control score: sum scores 8a – 14a

Other bowel symptoms


15 Using the pictures please indicate how your bowel movements are most of the time? (Tick all boxes that apply)


separate hard lumps like nuts (hard to pass)  (a) 1

sausage-shaped but lumpy  2

like a sausage but with cracks on its surface  3

like a sausage or snake – smooth and soft  4

soft blobs with clear cut edges (easy to pass)  5

fluffy pieces with ragged edges, a mushy stool  6

watery, no solid pieces  7

(b) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

16 Do you need to strain to open your bowels? (Tick one box)

(a)

never 0

rarely 1

some of the time 2

most of the time 3

always 4

(b) **How much does this bother you?**
 Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
 not at all a great deal

17 Is the possibility of having a bowel accident on your mind? (Tick one box)

(a)

never 0

rarely 1

some of the time 2

most of the time 3

always 4

(b) **How much does this bother you?**
 Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
 not at all a great deal

Sexual impact

18 Do you restrict your sexual activities because of your bowels? (Tick one box)

(a)

never 0

rarely 1

some of the time 2

most of the time 3

always 4

not applicable 5

(b) **How much does this bother you?**
 Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
 not at all a great deal

Quality of life

19 Do your bowels cause you to feel embarrassed? (Tick one box)

(a)

never	<input type="checkbox"/>	0
rarely	<input type="checkbox"/>	1
<u>some of the time</u>	<input type="checkbox"/>	2
<u>most of the time</u>	<input type="checkbox"/>	3
<u>always</u>	<input type="checkbox"/>	4

(b) **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
not at all										a great deal

20 Do your bowels cause you to make sure you know where toilets are? (Tick one box)

(a)

never	<input type="checkbox"/>	0
rarely	<input type="checkbox"/>	1
<u>some of the time</u>	<input type="checkbox"/>	2
<u>most of the time</u>	<input type="checkbox"/>	3
<u>always</u>	<input type="checkbox"/>	4

(b) **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
not at all										a great deal

21 Do your bowels cause you to make plans according to your bowels? (Tick one box)

(a)

never	<input type="checkbox"/>	0
rarely	<input type="checkbox"/>	1
<u>some of the time</u>	<input type="checkbox"/>	2
<u>most of the time</u>	<input type="checkbox"/>	3
<u>always</u>	<input type="checkbox"/>	4

(b) **How much does this bother you?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0	1	2	3	4	5	6	7	8	9	10
not at all										a great deal

22 Do your bowels cause you to stay home more often than you would like?

(Tick one box)

(a)
never 0

rarely 1

some of the time 2

most of the time 3

always 4

(b) How much does this bother you?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

23. Overall, how much do your bowels interfere with your everyday life?

Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10
not at all a great deal

Quality of life score: sum scores 19a -23

24 Please use the space below to describe any worries you have about bowel accidents or leakages, what you think may have caused your bowel accidents or leakages, or anything else you think we should know.

Please return this questionnaire to lyndsey.smith@kingstonhospital.nhs.uk if you have ticked any box highlighted within the red square and would like to be contacted regarding a follow up appointment.

Thank you very much for answering these questions.