

**BOWEL FUNCTION DIARY
MODULE 1: BOWEL MOVEMENT EVENT LOG**

The purpose of this section of the diary is to collect some information about each bowel movement you had today. Please read each question carefully, answering as openly as you can and without help from anyone.

Please answer the following questions to describe each bowel movement you had **within the past 24 hours**. For each question, please mark (✓ or ✗) the **one** answer most appropriate for that bowel movement.

1. Please record the time when this bowel movement occurred.

Hour and minute	AM/PM
____:____	AM: <input type="checkbox"/> PM: <input type="checkbox"/>

2. How much did you have to strain during this bowel movement?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

3. During this bowel movement, how much did you feel that you were able to fully empty your bowels?

Not at all	Slightly	Moderately	Quite a bit	Completely
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

4. How much pain did you have around your rectum during this bowel movement?

None	Mild	Moderate	Severe	Very severe
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

5. During this bowel movement, how would you describe the shape and consistency of your stool? <NOTE: Images from Bristol Stool Chart are shown also>

Separate hard lumps, like nuts (hard to pass)	Sausage-shaped but lumpy	Like sausage but with cracks on its surface	Like a sausage or snake, smooth and soft	Soft blobs with clear-cut edges (passed easily)	Fluffy pieces with ragged edges, a mushy stool	Watery, no solid pieces. Entirely Liquid
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

BOWEL FUNCTION DIARY
MODULE 2: SYMPTOM ASSESSMENT

The purpose of this section of the diary is to find out about the side effects of your pain medication and how you felt today.

Please answer the following questions to describe any constipation-related side effects from your pain medication **within the past 24 hours**. For each question, please mark (✓ or x) the **one** answer most appropriate to you.

1. In the **past 24 hours**, how often were you unable to have a bowel movement even though you felt like you had to?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

2. In the **past 24 hours**, how much bloating did you feel because of constipation?

None	Very mild	Mild	Moderate	Severe	Very severe
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

3. In the **past 24 hours**, how much pain did you feel in your abdomen because of constipation?

None	Very mild	Mild	Moderate	Severe	Very severe
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

4. In the **past 24 hours**, how much were you bothered by gas?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

5. In the **past 24 hours**, how much were you bothered by a lack of appetite because of constipation?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

BOWEL FUNCTION DIARY
MODULE 3: SYMPTOM MANAGEMENT

The purpose of this section of the diary is to collect some information things you may have done to try and ease your constipation **within the past 24 hours**. Please answer as openly as you can and without help from anyone.

1. Have you used any of the following treatments or medications within the **past 24 hours** to ease your constipation? (Please check all that apply or choose "none")

Extra fiber	<input type="checkbox"/>
Stool softener	<input type="checkbox"/>
Laxative	<input type="checkbox"/>
Enema	<input type="checkbox"/>
Suppository	<input type="checkbox"/>
Something else	<input type="checkbox"/>
None of these	<input type="checkbox"/>

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