

## IBS Sympton Checklist

I experience:

Abdominal pain or discomfort	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Bloating and/or excess wind (flatulence)	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Constipation	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Diarrhoea	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Indigestion	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Other symptoms (please describe):			
Over what time scale do you experience these symptoms?	<input type="checkbox"/> Hours	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks
If you suffer from abdominal pain, does the pain disappear after a bowel movement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have feelings of urgency when going to the toilet? <input type="checkbox"/> Yes <input type="checkbox"/> No
When you have a bowel movement do you have to strain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When you have finished do you feel as though you have fully evacuated your bowel? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long ago did you first start experiencing symptoms?	Does this coincide with any change in your eating habits?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your symptoms appear more when you feel stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you taking any medication to relieve any of the symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide details of any medication you are taking:			