THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

ARMUS INSTRUCTIONS

PLEASE READ ALL OF THE INSTRUCTIONS VERY CAREFULLY AND FOLLOW THEM EXACTLY AS ADVISED. REMEMBER ABSOLUTELY NOTHING TO EAT AFTER MIDNIGHT THE NIGHT BEFORE THE STUDY.

PARTIAL BOWEL PREP THE DAY BEFORE YOUR STUDY:

1. You may begin a clear liquid diet as soon as you awaken in the morning.
2. DO NOT eat any solid food or milk products.
3. AVOID any foods and drinks with red, orange, or blue food coloring.
4. You may have clear liquids all day such as water, coffee (black only), tea, carbonated beverages, apple or white grape juice, yellow Jell-O, fruit flavored drinks and powders, clear broth, bouillon, hard candy and banana popsicles.

AFTER YOUR SUPPERTIME LIQUIDS AROUND 5:00 PM YOU WILL NEED TO DO A WARM TAP WATER ENEMA. **DO NOT USE A FLEET ENEMA** – IF YOU MUST PURCHASE A FLEET ENEMA DISCARD THE SOLUTION AND FILL WITH WARM TAP WATER**.** IF YOU FEEL THAT THE FIRST ENEMA WAS NOT EFFECTIVE, YOU WILL NEED TO REPEAT AROUND 7:00 PM.

DO NOT USE ANOTHER ENEMA ON THE MORNING OF YOUR STUDY.

Genitorectal Disorders Center
Modified Manchester Questionnaire

Study ID#:__ __ __ __ Name Code: __ __ __ . __ __ Visit Date:__ __/__ __/__ __ __ __ (Month/day/year) __ __ __ Int. Initials

Thank you for answering these questions for us. In this next section we want to ask you a series of questions about problems that you might experience with your bowels. Again, please choose one of the answers that best describes your situation.

Modified Manchester

1. How often do you have a strong desire to move your bowels which makes you rush to the toilet? _____
   1. Never
   2. Occasionally
   3. Sometimes
   4. Most of the time
   5. All of the time

2. How often in the past month have you experienced any amount of accidental bowel leakage that consisted of solid stool? _____
   1. Never
   2. 1 to 3 times a month
   3. Once a week
   4. 2 or more times a week
   5. Once a day
   6. 2 or more times a day

If NEVER (1) skip to question 3

   2a. I can't hold solid stool long enough to get to the bathroom. _____
   1. Never
   2. Occasionally
   3. Sometimes
   4. Most of the time
   5. All of the time

   2b. Do you lose any solid stool when coughing or sneezing? _____
   1. Never
   2. Occasionally
   3. Sometimes
   4. Most of the time
   5. All of the time

   2c. Do you lose any solid stool when walking? _____
   1. Never
   2. Occasionally
   3. Sometimes
   4. Most of the time
   5. All of the time

   2d. Besides coughing, sneezing and walking, do you lose any solid stool during the rest of the day or night? _____
   1. Never
   2. Occasionally
   3. Sometimes
   4. Most of the time
   5. All of the time

3. How often in the past month have you experienced any amount of accidental bowel leakage that consisted of liquid stool? _____
   1. Never
   2. 1 to 3 times a month
   3. Once a week
   4. 2 or more times a week
   5. Once a day
   6. 2 or more times a day

If NEVER (1), skip to question 4

   3a. I can't hold liquid stool long enough to get to the bathroom. _____
   1. Never
   2. Rarely
   3. Sometimes
   4. Often
   5. Always

   3b. When you leak stool, how often is it liquid or watery? _____
   1. Never
   2. Rarely
   3. Sometimes
   4. Often
   5. Always

   3c. Do you lose any liquid stool when coughing or sneezing? _____
   1. Never
   2. Rarely
   3. Sometimes
   4. Often
   5. Always

   3d Do you lose any liquid stool when walking? _____
   1. Never
   2. Rarely
   3. Sometimes
   4. Often
   5. Always

   3e. Besides coughing, sneezing and walking, do you lose any liquid stool during the rest of the day or night? _____
   1. Never
   2. Rarely
   3. Sometimes
   4. Often
   5. Always

4. How often in the past month have you experienced any amount of accidental bowel leakage that consisted of mucus? _____

1. Never
2. 1 to 3 times a month
3. Once a week
4. 2 or more times a week
5. Once a day
6. 2 or more times a day

5. How often in the past month have you experienced any amount of accidental bowel leakage that consisted of gas? _____

1. Never
2. 1 to 3 times a month
3. Once a week
4. 2 or more times a week
5. Once a day
6. 2 or more times a day

If NEVER (1) skip questions 5a – 5e

5a. I can't hold gas long enough to get to the bathroom (or another safe place). _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

5b. Do you lose any gas when coughing or sneezing? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

5c. Do you lose any gas when walking? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

5d. Besides coughing, sneezing and walking, do you lose any gas during the rest of the day or night? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

5e. Do you have difficulty controlling gas? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Thank you very much. Your answers to these questions are very import to us.

Did you answer NEVER to all of the above questions? (1 thru 5)
If "Yes", STOP HERE;
If "No" Continue

Some women find that their bowel symptoms affect their activities, relationships and feelings. The next set of questions has to do with areas in your life which may have been affected by your bowel symptoms. Please choose one answer that best describes you and your situation.

1. How much do you think your bowel problem affects your life? _____

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

2. How often do you move your bowels each day? _____

1. 1 – 2 times a day
2. 3 – 4 times a day
3. 5 – 6 times a day
4. 7 or more times a day
5. Every other day
6. Less than every other day

3. Do you have difficulty wiping clean after You have moved your bowels? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

4. What percent of your bowel movements are hard or little balls? _____

1. 0
2. 25%
3. 50%
4. 75%
5. 100%

5. What percent of your bowel movements are loose or watery? _____

1. 0
2. 25%
3. 50%
4. 75%
5. 100%

We now have a series of questions about whether you have a problem with your bowels that limits your activities.

Role limitations

6. Do you have a problem with your bowels that affects doing jobs within the home? Yes No

6a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

7. Do you have a problem with your bowels that affects your job, or your normal daily activities outside the home? Yes No

If no, skip to question 8

7a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Physical / social limitations

8. Do you have a problem with your bowels that affects your ability to travel? Yes No

If no, skip to question 9

8a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

9. Do you have a problem with your bowels that affects your physical activities (such as going for a walk, running, sport, gym, etc)? Yes No

If no, skip to question 10

9a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

10. Do you have a problem with your bowels that limits your social life? Yes No

If no, skip to question 11

10a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

11. Do you have a problem with your Bowels that limits your ability to see and visit friends? Yes No

If no, skip to question 12

11a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Personal relationships

12. Do you have a problem with your bowels that affects your relationship with your partner? Yes No

If no, skip to question 13

12a. If yes, how often does it affect your relationship? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

13. Do you have a problem with your bowels that affects your family life? Yes No

If no, skip to question 14

13a. If yes, how often does it affect your family life? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Emotions

14. Do you have a problem with your bowels that makes you feel depressed? Yes No

If no, skip to question 15

14a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

15. Do you have a problem with your bowels that makes you feel anxious or nervous? Yes No

If no, skip to question 16

15a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

16. Do you have a problem with your bowels that makes you feel bad about yourself? Yes No

If no, skip to question 17

16a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Sleep / energy

17. Do you have a problem with your bowels that affects your sleep? Yes No

If no, skip to question 18

17a. If yes, how often does it affect your sleep? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

18. Do you have a problem with your bowels that makes you feel worn out and tired? Yes No

If no, skip to question 19

18a. If yes, how often does it affect you? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Sexual Activity

The next set of items covers material that s very sensitive and personal. Specifically, these questions ask about matters related to your sexual activity. While we hope you are willing to answer all of the questions, if there are any questions you would prefer not to answer, you are free to skip them.

19. Are you sexually active? Yes No

20. Do you have a problem with your bowels that affects your sex life? Yes No N/A

20a. If so, how often does it affect your sex life? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

21. Do you lose any gas during or after sexual activity? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

22. Do you lose any stool during or after sexual activity? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

23. Do you lose any urine during or after sexual activity? _____

1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Lifestyle Adaptation

24. Do you wear pads to keep clean because of a problem with your bowels? Yes No
If no, skip to question 25

24a. If yes, how often do you wear pads? _____
1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

25. Are you careful about how much food you eat because of a problems with your bowels? Yes No
If no, skip to question 26

25a. If yes, how often are you careful about how much food you eat? _____
1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

26. Do you change your underclothes because they get dirty due to a problem with your bowels? Yes No
If no, skip to question 27

26a. If yes, how often do you change your underclothes for this reason? _____
1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

27. Do you worry about odor because of a problem with your bowels? Yes No
If no, skip to question 28

27a. If yes, how often do you worry about it? _____
1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

28. Do you get embarrassed because of a problem with your bowels? Yes No
If no, skip to question 29

28a. If yes, how often do you get embarrassed? _____
1. Never
2. Rarely
3. Sometimes
4. Often
5. Always

Medical

29. Did you bring any of your bowel symptoms to the attention of your clinician? Yes No

30. Have you received treatment for your bowel symptoms? Yes No
If no, skip to question 31

30a. If "Yes", please specify: _____
1. Medical
2. Behavioral
3. Pelvic Muscle Exercise

31. Do you have any comments that are important to you which have not been covered?

Data Entry Initials: ___ ___ ___

Entry Date: ___ ___ / ___ ___ / ___ ___ ___ ___

Genitorectal Disorder Center
SF-12 Questionnaire

Study ID # __ __ __ __ Name Code: __ __ __ . __ __ DOV: __ __/__ __/__ __ __ __ (Month / D ay / Year) __ __ __ Int. Initials

We'll begin with some general questions about how you've been feeling.

1. In general, would you say your health is: _____
   1. Excellent
   2. Very Good
   3. Good
   4. Fair
   5. Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, playing golf? _____
   1. Yes, limited a lot
   2. Yes, limited a little
   3. No, not limited at all

3. Climbing several flights of stairs? _____
   1. Yes, limited a lot
   2. Yes, limited a little
   3. No, not limited at all

During the past four weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like? _____
   1. All of the time
   2. Most of the time
   3. Some of the time
   4. A little of the time
   5. None of the time

5. Were limited in the kind of work or other activities? _____
   1. All of the time
   2. Most of the time
   3. Some of the time
   4. A little of the time
   5. None of the time

During the past four weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like? _____
   1. All of the time
   2. Most of the time
   3. Some of the time
   4. A little of the time
   5. None of the time

7. Did work or activities less carefully than usual? _____
   1. All of the time
   2. Most of the time
   3. Some of the time
   4. A little of the time
   5. None of the time

8. During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework? _____
   1. Not at all
   2. A little bit
   3. Moderately
   4. Quite a bit
   5. Extremely

The next questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

9. How much of the time during the past four weeks have you felt calm and peaceful? _____
   1. All of the time
   2. Most of the time
   3. Some of the time
   4. A little of the time
   5. None of the time

10. Ho w much of the time during the past four weeks did you have a lot of energy? _____
    1. All of the time
    2. Most of the time
    3. Some of the time
    4. A little of the time
    5. None of the time

11. Ho w much of the time during the past four weeks have you felt downhearted and depressed? _____
    1. All of the time
    2. Most of the time
    3. Some of the time
    4. A little of the time
    5. None of the time

12. Durin g the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? _____
    1. All of the time
    2. Most of the time
    3. Some of the time
    4. A little of the time
    5. None of the time

Data Entry Initials: __ __ __

Hunskaar Severity Index

1. How often do you experience urinary leakage? _____

1. Never
2. Less than once per month
3. A few times a month
4. A few times a week
5. Every day and/or night

(If your answer is Never (1), then skip the rest of this page, otherwise continue.)

2. How much urine do you lose each time? _____

1. Drops
2. Small splashes
3. More

3. Did you bring any of your bladder Symptoms to the attention of your clinician? Yes No

4. Have you received treatment for your bladder symptoms? Yes No

   If yes, please specify: _____

1. Medical
2. Behavioral
3. Pelvic Muscle Exercise
4. Surgical
5. Other

   4a. If Surgical (4), specify: _____

   _____

   4b. If Other (5), specify: _____

   _____

Data Entry Initials: ___ ___ ___

Entry Date___ ___/___ ___/___ ___ ___