Date: ______________

Dear ______________:

We would like to welcome you to University Colon & Rectal Surgery. We appreciate the trust you have placed in us.

You are scheduled to see Dr. Casillas/ Dr. Russ/Niki Lovelace, NP on ______________, at ________ EST. Please arrive 15 minutes prior to your appointment to allow us to complete your registration. If you should arrive 15 minutes after your scheduled appointment time above, you will be asked to reschedule. Transport Service is providing self-service wheelchairs at the entrances for patients who need assistance getting to and from their scheduled appointments. If you need assistance with navigation, please have a caregiver accompany you to your scheduled appointment.

Please find the enclosed paperwork needed for your first visit. It is imperative that you bring the completed paperwork with you to your first visit. We will require your current insurance card and a driver’s license at each visit. We will also require your co-payment at time of your visit or any applicable deductible amount. We ask that you prepare for your appointment by doing a Fleet’s enema ONE HOUR prior to leaving for your scheduled appointment time, unless instructed otherwise.

Our billing is performed at a central location, not in our office. The billing office hours are the same as our office hours, Monday through Friday 8:00 am to 4:30 pm. If you have any billing questions, please call 865-670-6199.

Parking is available underneath our building, Building D. A sign on the building says Day Surgery. As you search for a parking space, attempt to park towards Alcoa Hwy and find the elevator underneath our building. Parking costs $3.00 and is paid as you leave the medical center. Enclosed is a map to help you find our building and the correct parking area. Use the elevators directly underneath our building to reach our office on the third floor. We are to the left once you get off the elevator.

If you have any questions, please feel free to call us at 865-305-5335.

Sincerely,

Patient Service Representative
Entrance to Building D is labeled ‘Day Surgery’. It is located on a down ramp located here.

Endoscopy Suite is here.

Parking Garage D is full. Parking is available on Alcoa Hwy.
Mark A. Casillas, Jr., MD, MS, FACS, is board certified by the American Board of Surgery and the American Board of Colon and Rectal Surgery. He is a fellow of the American College of Surgeons and member of multiple national societies.

Dr. Casillas specializes in the diagnosis and treatment of malignant and benign diseases of the colon, rectum, and anus with an emphasis on minimally invasive approaches for the management of colorectal problems including advances in laparoscopy, single incision laparoscopy, robotic surgery, transanal minimally invasive surgery, and many other techniques. We offer state of the art screening for colon and rectal problems and treat complex disorders including but not limited to: diverticulitis, inflammatory bowel disease (Crohn’s and Ulcerative colitis), hemorrhoids, anal fissures, anal fistulas, fecal incontinence, pelvic floor abnormalities, as well as many others. For details regarding the problems we treat, please visit our website at http://www.utcolorectal.org

Dr. Casillas is an Assistant Professor in the Division of Colorectal Surgery at the University of Tennessee Graduate School of Medicine Department of Surgery. He received a Bachelor’s in Microbiology from the University of Alabama. He completed a Master’s degree in Molecular Biology at the University of Alabama at Birmingham (UAB), and earned his Medical Doctorate from the University of Alabama School of Medicine (UAB). He performed his intern year at Brown University School of Medicine, and then completed his general surgery training at St. Joseph Mercy Hospital, Ann Arbor. Dr. Casillas completed a subspecialty fellowship in Colon & Rectal Surgery at Indiana University School of Medicine, and joined the faculty at the University of Tennessee Medical Center in 2012.

Dr. Casillas has written and presented articles and abstracts on a variety of subjects including basic science cancer research, robotic colon and rectal surgery, as well as single incision laparoscopic colon and rectal surgery. His research interests include minimally invasive approaches to colon and rectal cancer, robotic surgery, surgical resident education, and simulation.
Andrew J. Russ, MD, is an Assistant Professor of Surgery and Colorectal Surgery within the Division of Colorectal Surgery at the University of Tennessee Graduate School of Medicine and Department of Surgery. He received his Bachelor’s degree in Zoology from Miami University in Ohio and earned his Medical Doctorate from Wright State University Boonshoft School of Medicine. His general surgery training was at the University of Wisconsin in Madison, WI. Dr. Russ spent an additional two years under an NIH funded surgical oncology grant to study tumor immunology in a murine model at the University of Wisconsin.

Additionally, Dr. Russ completed a subspecialty fellowship in Colon and Rectal Surgery at University Hospitals Case Medical Center, in Cleveland, OH where he received additional training in the treatment of Colon and Rectal disorders, with concentration on minimally invasive approaches to colorectal disease.

Dr. Russ has authored numerous peer reviewed articles and book chapters, along with national presentations at forums such as the American Society of Colon and Rectal Surgeons, the American College of Surgeons, and the Society of Surgical Oncology. His research interests include Colorectal Cancer, advancements in simulation, quality improvement, technological advancements in colorectal surgery, the importance of the gut microbiome, colorectal cancer outcome disparities, and surgical education.

Dr. Russ is board certified by the American Board of Surgery and the American Board of Colon and Rectal Surgeons. Dr. Russ specializes in the diagnosis and treatment of diseases of the gastrointestinal tract, including the small intestine, colon, rectum, and anus. This includes colorectal cancer, diverticular disease, complex anorectal disease (incontinence, pelvic floor disorders, anal fissures, anal fistulae, hemorrhoids) and inflammatory bowel disease (Crohn disease and Ulcerative Colitis). His clinical interests include minimally invasive approaches (Robotic and Laparoscopic) to complex colorectal disease.
# PATIENT REGISTRATION

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<thead>
<tr>
<th>Date</th>
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## PATIENT INFORMATION

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<td>Email Address</td>
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<td>Gender (circle as many as are appropriate)</td>
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<tr>
<td>Current sex: Male Female Transgender Other</td>
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<td>Other</td>
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<td>Employer</td>
<td>Referring Physician</td>
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**How did you hear of us?**

## PRIMARY INSURANCE INFORMATION

**PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST**

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## SECONDARY INSURANCE INFORMATION

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## EMERGENCY CONTACT

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<td>Work Phone</td>
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## SPOUSE/GUARANTOR/RESPONSIBLE PARTY

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<td>Employer</td>
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<td>City</td>
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**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:** I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

**SIGNATURE** (Patient or Parent if Minor) | **DATE**
Insurance Payment Policy

Thank you for choosing University Colon & Rectal Surgeons. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross/Blue Shield, Blue Care, Champus-military only, Cigna, the Initial Group, Humana, Americhoice Tenncare, United Health and most Medicare Advantage plans. We are not in-network providers for UHC Secure Horizon. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.

2. **Co-payments.** All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit to your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.

4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.

5. **Claim submission.** We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any money’s owed after we have received payment from Medicare and/or a secondary policy that you might have.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.

7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Partial payments are accepted as long as you call them directly to set up the necessary payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by all guidelines:**

_________________________________________                              _____________________
Signature of Patient or Responsible Party                                              Date
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(All sections must be completed)

Patient Name: ____________________________ Date of birth: ____________

SSN: ____________ Address: __________________________

I hereby authorize the release of medical records to University Colon & Rectal Surgeons

Records to be released from: __________________________

For the following purpose: Medical Treatment

The authorization will expire on: _______________

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, Condition or dates of treatment: __________________________

_____ Specific records to be released (eg. Labs, imaging reports, other):

_______________________________________

_______________________________________

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance and thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient ____________________________ Date ____________________________
Patient Name:____________________________________ Date of Birth:__________________

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at:
______Home #____________________________________
______Cell #____________________________________
______Work #____________________________________
______Other #____________________________________

______May ONLY leave information with me. (If you check here, no other choice should be marked).
______May leave appointment reminders on my answering machine/voicemail.
______May leave lab results on my answering machine/voicemail.
______May leave general questions/information on my answering machine/voicemail.
______May send confidential messages regarding appointments, lab results, or general messages to your patient portal account
______May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:
Name:____________________________________Relationship:____________________
Name:____________________________________Relationship:____________________

______May leave appointment reminders with the above listed person
______May leave lab results with the above listed person
______May leave general questions/information with the above listed person
______May discuss billing information with the above listed person
______I prefer that all healthcare messages be given to the above listed person

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

Signature of Patient____________________________________ Date____________________
UNIVERSITY COLON AND RECTAL SURGERY
PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name: __________________________ Date of Birth: __________________ Age: ______________

Who recommended you to this office? ____________________________________________________________________________ Self Referral? [ ] Yes [ ] No

HISTORY OF PRESENT ILLNESS:
What is your reason for the office visit today? __________________________________________________________________________
When did this begin? ______________________ Have you ever had this problem before? [ ] Yes [ ] No
Has any other physician seen you for this condition? [ ] Yes [ ] No Name: ____________________________________________
Primary Care Physician (PCP): ______________________________________________________________________________________
Address: ________________________________________________________________________________________________________

MEDICAL HISTORY: Please check and/or circle all that apply

[ ] Alcoholism [ ] Glaucoma [ ] Prostate
[ ] Arthritis [ ] Heart Disease [ ] Enlarged (BPH)
[ ] Anxiety/Depression [ ] Abnormal Rhythm (Fibrillation) [ ] Cancer
[ ] Blood Clots ________ [ ] Congestive Heart Failure [ ] Psoriasis
[ ] Blood diseases [ ] Coronary Disease/Heart Attack [ ] Stroke/Seizures
   [ ] Anemia [ ] Heart Valve Disease [ ] Thyroid disease
   [ ] Leukemia [ ] Kidney disease [ ] High
[ ] Blood pressure – high [ ] Kidney stones [ ] Low
[ ] Blood transfusion (date) ________ [ ] Dialysis [ ] Tuberculosis
[ ] Bronchitis [ ] Liver Disease [ ] Cancer - type (s)
[ ] Cataracts [ ] Hepatitis [ ] ________________________________________________________________________________
[ ] Cholesterol-high [ ] Cirrhosis [ ] Osteoporosis
[ ] Diabetes (Insulin/Pills) [ ] Lung Disease [ ] Parkinson’s disease
[ ] Drug addiction [ ] Asthma [ ] Multiple Sclerosis
[ ] Epilepsy (Seizures) [ ] COPD/Emphysema [ ] _____________________________________________________________________

GI HISTORY:

[ ] Inflammatory Bowel Disease [ ] Colon Cancer [ ] Rectal Cancer
[ ] Crohn’s disease [ ] Colon Polyps [ ] Anal Cancer
[ ] Ulcerative Colitis [ ] Stomach Disease [ ] Anorectal Abscess
[ ] Irritable Bowel syndrome [ ] Reflux/GERD [ ] Anorectal Fistula
[ ] Anal Fissure [ ] Ulcers [ ] Hemorrhoids

HAVE YOU HAD A COLONOSCOPY? [ ] Yes [ ] No
DATE OF MOST RECENT COLONOSCOPY? _______________________________ PERFORMED BY? __________________________
WHAT WERE YOUR FINDINGS? __________________________________ ANY POLYPS OR LESIONS? ________________
DRUG ALLERGIES: [ ] None [ ] List Allergies ___________________________________________________
                                                                                             ___________________________________________________

MEDICATIONS:

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<th>Medication</th>
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PAST PROCEDURE HISTORY: (Year/ Reason/ Complications)

[ ] Colon Surgery ____________________________ [ ] Cardiac (heart) Surgery ____________________________
[ ] Anal/Rectal Surgery ______________________ [ ] Coronary Bypass ____________________________
[ ] hemorrhoids _____________________________ [ ] Coronary Stent ____________________________
[ ] fissure _________________________________ [ ] Valve Replacement ____________________________
[ ] other _________________________________ [ ] Pacemaker ____________________________
[ ] Colonoscopy _____________________________ [ ] Lung Procedure ____________________________
[ ] Virtual Colonoscopy ______________________ [ ] Skin Cancer Surgery ____________________________
[ ] Flexible Sigmoidoscopy ____________________ [ ] Arthroscopy ____________________________
[ ] Barium Enema ____________________________ [ ] Joint Replacement ____________________________
[ ] Other Bowel Surgery ______________________ [ ] Prostate Procedure ____________________________
  What location? _____________________________ [ ] Hysterectomy ____________________________
[ ] Appendectomy ____________________________ [ ] Cesarean Section ____________________________
[ ] Gallbladder Procedure ____________________ [ ] D&C ____________________________
[ ] Other Abdominal Surgery __________________ [ ] Back Procedure ____________________________
  What? ____________________________ [ ] Neck Procedure ____________________________
[ ] Hernia repair ____________________________ [ ] Kidney Procedure ____________________________
[ ] Cataract Procedure ______________________ [ ] Breast Procedure ____________________________
[ ] Tonsillectomy ____________________________ [ ] Other ____________________________

PREGNANCY HISTORY:

Number of Pregnancies ____________________________ Tears/Episiotomy ____________________________
Number of Vaginal Deliveries ______________________ Age when first pregnant ______________________
Number of C-Sections ____________________________ Date of last delivery ____________________________
Miscarriage/ Abortion ____________________________

How many times per week do you have a Bowel Movement? ____________________________
Do you have fecal smearing? [ ] Yes [ ] No
Which laxative(s) do you use? ____________________________ When did this begin? ____________________________
Do you have fecal incontinence? [ ] Yes [ ] No
How frequent are your bowel accidents? ______________________
SOCIAL HISTORY:

[ ] Yes [ ] No  Have you ever smoked tobacco? How much per day? ___________ How many years? ___________
  When did you quit? ____________

[ ] Yes [ ] No  Have you ever taken banned substances? What substance? ________________________________

[ ] Yes [ ] No  Are you currently taking any over the counter drugs? What drugs? ___________________________

[ ] Yes [ ] No  Are you currently taking any herbal drugs? What drugs? _________________________________

[ ] Yes [ ] No  Do you consume Alcohol? How many drinks per day/week? _______________________________

[ ] Yes [ ] No  Are you currently taking any diet pills? What pills? _______________________________________

[ ] Yes [ ] No  Are you currently taking any blood thinners? (Aspirin, Ibuprofen, Coumadin, Xarelto, Plavix, Vit. E etc.)

[ ] Yes [ ] No  Are you currently employed? What is your profession? _________________________________

[ ] Yes [ ] No  Are you married? Other relationship? (NAME) _______________________________________

[ ] Yes [ ] No  Are you sexually active? What is your sexual Preference? [ ] MEN [ ] WOMEN [ ] BOTH

[ ] Yes [ ] No  History of Anal Receptive Intercourse?

FAMILY HISTORY:

Please list any blood relative and their relationship to you that have had any of the following:

Colon polyps: _____________________________ Colon Cancer: ________________________________

Crohn’s Disease/Ulcerative Colitis: ____________ Rectal Cancer: _____________________________

Anal Cancer: _____________________________ Other Cancer: _________________________________

Diabetes: ________________________________ High Blood Pressure: _____________________________

Heart Disease: ___________________________ Lung Disease: ________________________________

Breast Cancer: __________________________ Endometrial Cancer: ____________________________

Ovarian Cancer: _________________________ Gastric/Small Intestine Cancer: ____________________

Other: ____________________________________________________________
REVIEW OF SYSTEMS: Please circle if positive, or circle [-] if all negative

[-] **Constitutional:** Weight loss, # of pounds? _____ Fever Chills Sweats Weakness Fatigue Decreased activity
   Over what duration? _____ Other ______________

[-] **Eyes:** Visual problems Yellowing of eyes Discharge Blurring Double vision Visual Disturbances OTHER __________

[-] **HEENT:** Decreased Hearing Ear pain Ringing in Ears Nasal Congestion Sore throat OTHER ______________________

[-] **Respiratory:** Shortness of breath Cough Sputum Production Coughing up Blood Wheezing Apnea OTHER ______

[-] **Cardiovascular:** Chest Pain Palpitations Fast/Slow Heart Rate Leg Swelling Passing out OTHER ______________

[-] **Breast:** Lump/mass Nipple changes Swelling Pain Redness Nipple discharge OTHER ______________

[-] **GI:** Nausea Vomiting Bloody vomit Diarrhea Constipation Heartburn Incontinence (Stool/liquid/gas)
   Dark Stool Hemorrhoids Prolapse/Tissue coming out Inability to evacuate Anorectal pain: When? _______
   Rectal Pain awakens at night Excessive Mucus with BM Rectal burning/ itching/ discharge OTHER ______

[-] **Genitourinary:** Burning/Pain with Urination Blood in urine Change in stream Discharge Lesions/growths
   Urinary incontinence OTHER ______________

[-] **Gynecologic:** Vaginal bulge with BM or Straining Splinting of perineum to evacuate stool Vaginal discharge
   Last menstrual cycle ______ Abnormal vaginal bleeding Air per vagina OTHER ______

[-] **Heme/Lymph:** Bruising tendency Bleeding tendency Swollen lymph nodes OTHER ______________________

[-] **Endocrine:** Excessive thirst Increased urination Cold intolerance Heat intolerance Excessive Hunger OTHER ______

[-] **Immunologic:** Recurrent fevers Recurrent infections OTHER ______________________________

[-] **Musculoskeletal:** Back pain Neck pain Joint pain Muscle pain Pain with walking Trauma OTHER __________

[-] **Skin:** Jaundice Rash Abrasions Burns Dryness Scarring Lesions/masses OTHER ______________

[-] **Neurologic:** Headache Confusion Numbness/Tingling Abnormal Balance OTHER ______________________

[-] **Psychiatric:** Anxiety Depression Mania Suicidal Hallucinations Delusions OTHER __________

Other: ____________________________________________________________________________________________

History of Sexually Transmitted Diseases: [ ] Yes [ ] No What type? ________________________________


BOWEL CONTROL SATISFACTION SURVEY

Name ________________________________

Which symptoms best describe you?

- Bowel accidents because I am unable to make it to the bathroom in time
- Bowel accidents while asleep/ unaware
- Frequent loose, watery stools
- Abdominal pain

How long have you had these symptoms? ________________________________

Approximately how many bowel accidents do you have per week? __________

Behavior modifications tried _____________________________________________
(i.e., lifestyle changes, fiber, diet changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help you symptoms?

If yes, check the medications you have tried:

- Imodium
- Imotil
- Loperamide
- Lomotil
- Diphenoxylate
- Other _______________________

Did these medications help your symptoms?

If you’ve stopped taking your meds, explain why:

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? ________________

Are you interested in learning more about other treatment options?