

TELL ME ABOUT YOUR GUT

1.

How many bowel movements do you have in a week?

2.

Do you experience any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Straining (difficulty passing stools) |
| <input type="checkbox"/> Bloating / Distension | <input type="checkbox"/> Hard stools |
| <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Incomplete bowel movements |

Have you experienced these for more than 3 months?

- Yes No

Other Symptoms (please explain)

3.

Have you taken any prescription or over-the-counter medications to help you with your bowel movements in the last month?

- Yes No

If yes, which medication and how often do you take it?

4.

Have you experienced any changes in the frequency of your bowel movements or in the appearance of your stools?

- Yes No

If yes, please describe

5.

How satisfied are you with your bowel movements overall?

Very Dissatisfied

Dissatisfied

Neither Satisfied nor Dissatisfied

Satisfied

Very Satisfied



WHAT'S YOUR NUMBER?



Separate hard lumps, like nuts (hard to pass)



Sausage-shaped but lumpy



Like a sausage or snake but with cracks on the surface



Like a sausage or snake, smooth and soft



Soft blobs with clear-cut edges



Fluffy pieces with ragged edges, a mushy stool



Watery, no solid pieces
Entirely liquid

Modified from original version.
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Your doctor can help you find relief. Share this information at your next doctor visit. To help find the right treatment for you, your doctor needs to know all your symptoms and how they are affecting you.



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