IBS - SYMPTOM SEVERITY SCALE

IRRITABLE BOWEL SYNDROME STUDY

Patient Number [patid]

Protocol Number [study]

Date of Study Participant Visit/Contact [visitm] [ ][ ] mmm dd [ ][ ][ ][ ] yyyy

Institution Code [instn]

Form Week [week] *Seq No. [seqno] **Step No. [stepno] Key Operator Code [keyop]

This area completed by Clinic Staff only.

* Enter a '1' if this is the first of this form for this date. Designate subsequent forms on the same date with a 2, 3, etc.
** Enter the study participant's current study step number. Enter '1' if the study does not have multiple steps.

INSTRUCTIONS:
This form will help you describe the nature of your IBS. It is to be expected that your symptoms might vary over time, so please try and answer all the questions based on how you currently feel (i.e., over the last 10 days or so). All information will be kept in **strict** confidence.

1. For questions where a number of different responses are possible please circle the response appropriate to you.
2. Some questions will require you to write in an appropriate response.
3. Some questions require you to put a cross line which enables us to judge the severity of particular problem(s).

   For example:

   How severe was your pain?

   Please place your "x" anywhere on the line between 0 - 100% in order to indicate as accurately as possible the severity of your symptom.

   This example shows a severity of approximately 90%, with 100% representing "very severe" pain.

CONTINUE ON NEXT PAGE

Pt. No. ☐☐☐☐☐ *Seq. No. ☐☐ **Step No. ☐☐ Date ☐☐☐ (mmm) ☐☐ (dd) ☐☐☐☐ (yyyy)

1. Do you currently suffer from abdomen or belly pain? ……
   If No, go to 'b.'
   If Yes, continue.

   Check One

Yes	No
☐	☐
1	2

   For office use only: mb901

   SCORE

   a. Indicate with an "**X**" on the line below the severity of your abdomen or belly pain:

   0% ——— **100%**

   no pain | not very severe | quite severe | severe | very severe

   mb902

   b. Enter the number of days that you typically experience **abdominal pain *every 10 days:***
   (For example, if you enter 4, it means that you get pain 4 out of 10 days. If you get pain every day, enter 10.)

   mb903

   Number of days with pain: ……

2. Do you currently suffer from abdominal distension? ……
   (bloating, swollen or tight tummy)
   (*Women, please ignore distension related to your periods.)
   If No, go question 3.
   If Yes, continue.

   Check One

Yes	No
☐	☐
1	2

   mb904

   a. Indicate with an "**X**" on the line below the severity of your abdominal distension/ tightness:

   0% ——— **100%**

   no pain | not very severe | quite severe | severe | very severe

   mb905

3. Indicate with an "**X**" on the line below how satisfied you are with your bowel habits:

   0% ——— **100%**

   not at all satisfied | not too satisfied | somewhat satisfied | very satisfied

   mb906

4. Indicate with an "**X**" on the line below how much your Irritable Bowel Syndrome affects or interferes with your life in general:

   0% ——— **100%**

   not at all interferes | not much | quite a lot | completely interferes

   mb907

Date Form Keyed (DO NOT KEY): _____ / _____ / _____