

Name _____

Date _____

Wexner Score

Instructions

Please answer all of the questions in the following survey, according to your incidence of bowel (fecal) incontinence. Check one box for each item listed.

Rarely = Less than once per month

Sometimes = Between once per week and once per month

Often = Between once per day and once per week

Always = At least once per day

	Never	Rarely	Sometimes	Often	Always
Solid	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Liquid	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Gas	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Wears Pad	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lifestyle Alterations	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4