IBD Control

Inflammatory Bowel Disease Control Questionnaire

1 Do you believe that:

	Yes	No	Not sure
a. Your IBD has been well controlled in the past *two weeks*?	☐	☐	☐
b. Your *current treatment* is useful in controlling your IBD?	☐	☐	☐

(If you are not taking any treatment, please tick this box ☐)

2 Over the past 2 weeks, have your bowel symptoms been getting worse, getting better or not changed?	Better	No change	Worse
	☐	☐	☐

3 In the past 2 weeks, did you:

	Yes	No	Not sure
a. Miss any planned activities because of IBD? (e.g. attending school/college, going to work or a social event)	☐	☐	☐
b. Wake up at night because of symptoms of IBD?	☐	☐	☐
c. Suffer from significant pain or discomfort?	☐	☐	☐
d. Often feel lacking in energy (fatigued) (by 'often' we mean more than half of the time)	☐	☐	☐
e. Feel anxious or depressed because of your IBD?	☐	☐	☐
f. Think you needed a change to your treatment?	☐	☐	☐

4 At your next clinic visit, would you like to discuss:

	Yes	No	Not sure
a. Alternative types of drug for controlling IBD	☐	☐	☐
b. Ways to adjust your own treatment	☐	☐	☐
c. Side effects or difficulties with using your medicines	☐	☐	☐
d. New symptoms that have developed since your last visit	☐	☐	☐

5 How would you rate the OVERALL control of your IBD in the past *two weeks*?

Please draw a vertical line (|) on the scale below