

Appendix B

Research Diagnostic
Questions for
Functional
Gastrointestinal
Disorders

Rome II Modular
Questionnaire:
Investigator and
Respondent Forms

Investigator Version

— Information for Investigator

This questionnaire has been developed primarily for clinical investigation or clinical practice, though it may also be used in epidemiologic surveys. It is an updated version of the original US Householder's survey published in 1993 using Rome I criteria. This questionnaire contains the Rome II diagnostic criteria.

To make a diagnosis, the questionnaire criteria must be fulfilled as indicated in the coding form. The clinician or investigator must also determine that structural disease(s) that would explain these symptoms are excluded.

Note that the Rome criteria require that symptoms be present for at least 12 weeks (at least one day in that week) over the past year. However, the committee accepts that for survey purposes, symptoms might only be present in the previous three months. This questionnaire allows only for symptoms being present for at least 3 months.

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ROME II Modular Questionnaire: Investigator Form

Question	Answer
<p>Esophageal Disorders</p> <p><u>Globus</u></p> <p>1. In the last 3 months, did you <i>often</i>* get the feeling of a lump in your throat when you were <i>not</i> swallowing? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes → Skip to question 3.</p> <p>2. When you are eating or drinking, is it difficult to swallow, or does it hurt to swallow? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes</p>	
<p><u>Rumination Syndrome</u></p> <p>3. In the last 3 months, did you <i>often</i>* bring up food, chew it again, and either spit it out or re-swallow it? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes → Skip to question 6.</p> <p>4. At these times, did you vomit or feel sick to your stomach? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes</p> <p>5. Do you stop bringing up food when the food turns sour (acidic)? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes</p>	
<p><u>Functional Chest Pain of Presumed Esophageal Origin</u></p> <p>6. In the last 3 months, did you <i>often</i>* have pain in the middle of your chest (that is not due to angina or a heart attack)? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes → Skip to question 8.</p> <p>7. Did this chest pain occur when it felt like food got stuck going down? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes</p>	
<p><u>Functional Heartburn</u></p> <p>8. In the last 3 months, did you <i>often</i>* have heartburn, a burning pain or discomfort in your chest? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes</p>	
<p><u>Functional Dysphagia</u></p> <p>9. In the last 3 months, did you <i>often</i>* have difficulty after swallowing (solid or liquids sticking in your chest, or passing down abnormally)? <input type="checkbox"/>₀ No or rarely <input type="checkbox"/>₁ Yes</p>	

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Investigator Form

Question	Answer
Gastroduodenal Disorders	
<u>Functional Dyspepsia</u>	
10. In the last 3 months, did you <i>often</i> * have discomfort or pain centered in your upper abdomen (above your belly button, or the pit of your stomach)?	<input type="checkbox"/> No or rarely → Skip to question 15. <input type="checkbox"/> Yes
11. Check your best description of this symptom, or the one that bothers you more . . .	<input type="checkbox"/> <i>pain</i> in your upper abdomen or stomach → Skip to question 13. <input type="checkbox"/> <i>discomfort</i> (that is not painful) in your upper abdomen or stomach
12. If you have discomfort, which of the following describe your discomfort? (<i>check all that apply</i>)	<input type="checkbox"/> nausea <input type="checkbox"/> bloating (a sensation of upper abdominal swelling) <input type="checkbox"/> feeling full after eating very little <input type="checkbox"/> none of the above
13. Does your upper abdominal discomfort or pain usually get better or stop after you have a bowel movement?	<input type="checkbox"/> No or rarely <input type="checkbox"/> Yes
14a. When the upper abdominal discomfort or pain starts, do you usually have a change in your usual number of bowel movements (either more or fewer)?	<input type="checkbox"/> No or rarely <input type="checkbox"/> Yes
14b. When the upper abdominal discomfort or pain starts, do you usually have either softer or harder stools than usual?	<input type="checkbox"/> No or rarely <input type="checkbox"/> Yes

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Investigator Form

Question	Answer
<u>Aerophagia</u>	
15. In the last 3 months, did you <i>often</i> * burp or belch?	<input type="checkbox"/> ₀ No or rarely → Skip to question 17. <input type="checkbox"/> ₁ Yes
16. Did you swallow air to help you belch?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
<u>Functional Vomiting</u>	
17. In the last 3 months, did you have frequent episodes of vomiting (on at least 3 separate days in each week)?	<input type="checkbox"/> ₀ No or rarely → Skip to question 20. <input type="checkbox"/> ₁ Yes
18. During these episodes, did you make yourself vomit?	<input type="checkbox"/> ₀ No or rarely → Skip to question 20. <input type="checkbox"/> ₁ Yes
19. Were you vomiting because of a medication you were taking or another medical condition that you had?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
<u>Bowel Disorders</u>	
<u>Irritable Bowel Syndrome/</u>	
<u>Functional Abdominal Bloating/</u>	
<u>Functional Constipation</u>	
20. In the last 3 months, did you <i>often</i> * have discomfort or pain in your abdomen?	<input type="checkbox"/> ₀ No or rarely → Skip to question 24. <input type="checkbox"/> ₁ Yes
21. Does your discomfort or pain get better or stop after you have a bowel movement?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
22. When the discomfort or pain starts, do you have a change in your usual number of bowel movements (either more or fewer)?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
23. When the discomfort or pain starts, do you have either softer or harder stools than usual?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
<i>see question 24 on the next page</i>	

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Investigator Form

Question	Answer
24. Have you had any of the following symptoms at least one-fourth ($\frac{1}{4}$) of the time (occasions or days) in the last 3 months? (<i>check all that apply</i>)	<ul style="list-style-type: none"><li data-bbox="602 265 832 355"><input type="checkbox"/> ₁ Fewer than three bowel movements a week (0–2)<li data-bbox="602 361 832 451"><input type="checkbox"/> ₂ More than three bowel movements a day (4 or more)<li data-bbox="602 456 832 482"><input type="checkbox"/> ₃ Hard or lumpy stools<li data-bbox="602 487 832 546"><input type="checkbox"/> ₄ Loose, mushy or watery stools<li data-bbox="602 552 832 611"><input type="checkbox"/> ₅ Straining during a bowel movement<li data-bbox="602 616 832 706"><input type="checkbox"/> ₆ Having to rush to the toilet to have a bowel movement<li data-bbox="602 711 832 802"><input type="checkbox"/> ₇ Feeling of incomplete emptying after a bowel movement<li data-bbox="602 807 832 897"><input type="checkbox"/> ₈ Passing mucus (slime) during a bowel movement<li data-bbox="602 902 832 961"><input type="checkbox"/> ₉ Abdominal fullness, bloating or swelling<li data-bbox="602 966 832 1123"><input type="checkbox"/> ₁₀ A sensation that the stool cannot be passed (i.e., blocked) when having a bowel movement<li data-bbox="602 1128 832 1345"><input type="checkbox"/> ₁₁ A need to press on or around your bottom or vagina to try to remove stool in order to complete the bowel movement

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Investigator Form

Question	Answer
Functional Diarrhea	
25. In the last 3 months, did you have loose, mushy, or watery stools, during more than three quarters ($\frac{3}{4}$) of your bowel movements?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
Functional Abdominal Pain	
26. In the last 6 months, did you have pain in your abdomen all the time (continuously) or most of the time (nearly continuously)? <i>(If you are female, this should not be related to your menstrual cycle or period)</i>	<input type="checkbox"/> ₀ No → <input type="checkbox"/> ₁ Yes
	Skip to question 28.
27. Has this pain limited or restricted your ability to work or go to social events?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
Biliary Disorders	
28. In the last year, did you have any severe steady pain in the middle or right side of your upper abdomen?	<input type="checkbox"/> ₀ No or rarely → <input type="checkbox"/> ₁ Yes
	Skip to question 33.
29. Did the pain last 30 minutes or more?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
30. Did the pain keep you from your usual daily activities, or cause you to see a doctor?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
31. Have you had your gallbladder removed?	<input type="checkbox"/> ₀ No → <input type="checkbox"/> ₁ Yes
	Skip to question 33.
32. Did you have any severe or steady pain in the middle or right side of your upper abdomen since your gallbladder was removed?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Investigator Form

Question	Answer
Anorectal Disorders <u>Functional Incontinence</u>	
33. In the last year, when you had constipation or diarrhea, did you accidentally leak or pass stool for more than one occasion in a month?	<input type="checkbox"/> ₀ No → Skip to question 35. <input type="checkbox"/> ₁ Yes
34. How much stool did you accidentally lose? Would you say . . .	<input type="checkbox"/> ₁ A small amount (it stains underwear) <input type="checkbox"/> ₂ A moderate or large amount (2 teaspoons or more)
<u>Functional Anorectal Pain</u>	
35. In the last year, did you have more than one episode of aching pain or pressure in the anal canal or rectum?	<input type="checkbox"/> ₀ No → Skip to question 38. <input type="checkbox"/> ₁ Yes
<u>Levator Ani Syndrome/Proctalgia Fugax</u>	
36. Did this pain occur frequently or continuously in the last 3 months?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
37. Which of the following 2 statements better describes the aching, pain, or pressure that you had in the anal canal or rectum?	<input type="checkbox"/> ₁ Lasts from seconds to minutes and disappears completely <input type="checkbox"/> ₂ Lasts more than 20 minutes and up to several days or longer

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Investigator Form

Question	Answer
<p><u>Pelvic Floor Dyssynergia</u></p> <p>38. In the last 3 months, when you were having bowel movements, did you. . . (<i>check all that apply</i>)</p>	<p><input type="checkbox"/>₁ Feel as if you had to strain to pass your stool on at least one quarter of the time</p> <p><input type="checkbox"/>₂ Feel as if you were unable to empty the rectum at least one quarter of the time</p> <p><input type="checkbox"/>₃ Have difficulty relaxing or letting go to allow the stool to come out at least one quarter of the time</p> <p><input type="checkbox"/>₄ None of the above</p> <p><i>End of Questionnaire</i></p>

ROME II Modular Questionnaire: Respondent Form

Please read this first ...

Instructions

The purpose of this survey is to learn more about the health problems that people sometimes have with the stomach and intestines. The questionnaire will take about 15 minutes to complete. Your participation is voluntary, and you may refuse to answer any of the questions in the survey.

To answer each question, place a check mark inside the box directly to the left of the correct answer. You may find that you have not had some or any of the symptoms that we'll ask you about. When this happens, you will be instructed to skip over the questions that do not apply to you. *Please be careful to follow the skip instructions.* They are typed next to the response for "No or rarely". See the example below.

Question	Answer
3. In the last 3 months, did you <i>often</i> * bring up food, chew it again, and either spit it out or re-swallow it?	<input type="checkbox"/> ₀ No or rarely → Skip to question 6. <input type="checkbox"/> ₁ Yes

The questions will ask if you have the different symptoms *often*. By often, we mean that symptoms were present during at least 3 weeks (at least once a week) in the last 3 months. *Please keep this in mind as you answer the questions.*

If you are not sure about an answer, or you can't remember the answer to a question, just answer as best you can. It is easy to miss questions, so please check that you haven't left any out as you go.

Thank You!

Rome II Modular Questionnaire: Respondent Form

Question	Answer
Esophageal Symptoms	
1. In the last 3 months, did you <i>often</i> * get the feeling of a lump in your throat when you were <i>not</i> swallowing?	<input type="checkbox"/> ₀ No or rarely → Skip to question 3. <input type="checkbox"/> ₁ Yes
2. When you are eating or drinking, is it difficult to swallow, or does it hurt to swallow?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
3. In the last 3 months, did you <i>often</i> * bring up food, chew it again, and either spit it out or re-swallow it?	<input type="checkbox"/> ₀ No or rarely → Skip to question 6. <input type="checkbox"/> ₁ Yes
4. At these times, did you vomit or feel sick to your stomach?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
5. Do you stop bringing up food when the food turns sour (acidic)?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
6. In the last 3 months, did you <i>often</i> * have pain in the middle of your chest (that is not due to angina or a heart attack)?	<input type="checkbox"/> ₀ No or rarely → Skip to question 8. <input type="checkbox"/> ₁ Yes
7. Did this chest pain occur when it felt like food got stuck going down?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
8. In the last 3 months, did you <i>often</i> * have heartburn, a burning pain or discomfort in your chest (that is not due to angina or a heart attack)?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
9. In the last 3 months, did you <i>often</i> * have difficulty after swallowing (solid or liquids sticking in your chest, or passing down abnormally)?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Respondent Form

Question	Answer
Gastroduodenal Symptoms	
10. In the last 3 months, did you <i>often</i> * have discomfort or pain centered in your upper abdomen (above your belly button, or the pit of your stomach)?	<input type="checkbox"/> No or rarely → Skip to question 15. <input type="checkbox"/> Yes
11. Check your best description of this symptom, or the one that bothers you more . . .	<input type="checkbox"/> <i>pain</i> in your upper abdomen or stomach → Skip to question 13. <input type="checkbox"/> <i>discomfort</i> (that is not painful) in your upper abdomen or stomach
12. If you have discomfort, which of the following describe your discomfort? (<i>check all that apply</i>)	<input type="checkbox"/> nausea <input type="checkbox"/> bloating (a sensation of upper abdominal swelling) <input type="checkbox"/> feeling full after eating very little <input type="checkbox"/> none of the above
13. Does your upper abdominal discomfort or pain usually get better or stop after you have a bowel movement?	<input type="checkbox"/> No or rarely <input type="checkbox"/> Yes
14a. When the upper abdominal discomfort or pain starts, do you usually have a change in your usual number of bowel movements (either more or fewer)?	<input type="checkbox"/> No or rarely <input type="checkbox"/> Yes
14b. When the upper abdominal discomfort or pain starts, do you usually have either softer or harder stools than usual?	<input type="checkbox"/> No or rarely <input type="checkbox"/> Yes

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Respondent Form

Question	Answer
15. In the last 3 months, did you <i>often</i> * burp or belch?	<input type="checkbox"/> ₀ No or rarely → Skip to question 17. <input type="checkbox"/> ₁ Yes
16. Did you swallow air to help you belch?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
17. In the last 3 months, did you have frequent episodes of vomiting (on at least 3 separate days in each week)?	<input type="checkbox"/> ₀ No or rarely → Skip to question 20. <input type="checkbox"/> ₁ Yes
18. During these episodes, did you make yourself vomit?	<input type="checkbox"/> ₀ No or rarely → Skip to question 20. <input type="checkbox"/> ₁ Yes
19. Were you vomiting because of a medication you were taking or another medical condition that you had?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
Bowel Symptoms	
20. In the last 3 months, did you <i>often</i> have discomfort or pain in your abdomen?	<input type="checkbox"/> ₀ No or rarely → Skip to question 24. <input type="checkbox"/> ₁ Yes
21. Does your discomfort or pain get better or stop after you have a bowel movement?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
22. When the discomfort or pain starts, do you have a change in your usual number of bowel movements (either more or fewer)?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
23. When the discomfort or pain starts, do you have either softer or harder stools than usual?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
<i>see question 24 on the next page</i>	

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Respondent Form

Question	Answer
<p>24. Have you had any of the following symptoms at least one-fourth ($\frac{1}{4}$) of the time (occasions or days) in the last 3 months? (<i>check all that apply</i>)</p>	<p><input type="checkbox"/>₁ Fewer than three bowel movements a week (0–2)</p> <p><input type="checkbox"/>₂ More than three bowel movements a day (4 or more)</p> <p><input type="checkbox"/>₃ Hard or lumpy stools</p> <p><input type="checkbox"/>₄ Loose, mushy or watery stools</p> <p><input type="checkbox"/>₅ Straining during a bowel movement</p> <p><input type="checkbox"/>₆ Having to rush to the toilet to have a bowel movement</p> <p><input type="checkbox"/>₇ Feeling of incomplete emptying after a bowel movement</p> <p><input type="checkbox"/>₈ Passing mucus (slime) during a bowel movement</p> <p><input type="checkbox"/>₉ Abdominal fullness, bloating or swelling</p> <p><input type="checkbox"/>₁₀ A sensation that the stool cannot be passed (i.e., blocked) when having a bowel movement</p> <p><input type="checkbox"/>₁₁ A need to press on or around your bottom or vagina to try to remove stool in order to complete the bowel movement</p>

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Respondent Form

Question	Answer
25. In the last 3 months, did you have loose, mushy, or watery stools, during more than three quarters ($\frac{3}{4}$) of your bowel movements?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
Abdominal Pain Symptoms	
26. In the last 6 months, did you have pain in your abdomen all the time (continuously) or most of the time (nearly continuously)? <i>(If you are female, this should not be related to your menstrual cycle or period)</i>	<input type="checkbox"/> ₀ No → <input type="checkbox"/> ₁ Yes
	Skip to question 28.
27. Has this pain limited or restricted your ability to work or go to social events?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
Biliary Symptoms	
28. In the last year, did you have any severe steady pain in the middle or right side of your upper abdomen?	<input type="checkbox"/> ₀ No or rarely → <input type="checkbox"/> ₁ Yes
	Skip to question 33.
29. Did the pain last 30 minutes or more?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
30. Did the pain keep you from your usual daily activities, or cause you to see a doctor?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes
31. Have you had your gallbladder removed?	<input type="checkbox"/> ₀ No → <input type="checkbox"/> ₁ Yes
	Skip to question 33.
32. Did you have any severe or steady pain in the middle or right side of your abdomen since your gallbladder was removed?	<input type="checkbox"/> ₀ No or rarely <input type="checkbox"/> ₁ Yes

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Respondent Form

Question	Answer
Anorectal Symptoms	
33. In the last year, when you had constipation or diarrhea, did you accidentally leak or pass stool for more than one occasion in a month?	<input type="checkbox"/> ₀ No → Skip to question 35. <input type="checkbox"/> ₁ Yes
34. How much stool did you accidentally lose? Would you say . . .	<input type="checkbox"/> ₁ A small amount (it stains underwear) <input type="checkbox"/> ₂ A moderate or large amount (2 teaspoons or more)
35. In the last year, did you have more than one episode of aching pain or pressure in the anal canal or rectum?	<input type="checkbox"/> ₀ No → Skip to question 38. <input type="checkbox"/> ₁ Yes
36. Did this pain occur frequently or continuously in the last 3 months?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes
37. Which of the following 2 statements better describes the aching, pain, or pressure that you had in the anal canal or rectum?	<input type="checkbox"/> ₁ Lasts from seconds to minutes and disappears completely <input type="checkbox"/> ₂ Lasts more than 20 minutes and up to several days or longer

* *Often* means that the symptoms were present during at least 3 weeks (at least one day in each week) in the last 3 months.

Rome II Modular Questionnaire: Respondent Form

Question	Answer
<p>38. In the last 3 months, when you were having bowel movements, did you. . . (check all that apply)</p>	<p><input type="checkbox"/>₁ Feel as if you had to strain to pass your stool on at least one quarter of the time</p> <p><input type="checkbox"/>₂ Feel as if you were unable to empty the rectum at least one quarter of the time</p> <p><input type="checkbox"/>₃ Have difficulty relaxing or letting go to allow the stool to come out at least one quarter of the time</p> <p><input type="checkbox"/>₄ None of the above</p> <p><i>End of Questionnaire</i></p>

Codes for Rome II Modular Questionnaire

Esophageal Disorders

Globus	Q1 = Yes	Q2 = No	Q8 = No
Rumination Syndrome	Q3 = Yes	Q4 = No	Q5 = Yes
Functional Chest Pain of Presumed Esophageal Origin	Q6 = Yes	Q7 = No	Q8 = No
Functional Heartburn*	Q8 = Yes	Q9 = No	
Functional Dysphagia†	Q9 = Yes	Q8 = No	

Gastroduodenal Disorders

Functional Dyspepsia††	Q10 = Yes	Q8 = No	Q13 = No	Q14a = No	Q14b = No
Ulcer-like Dyspepsia	Functional dyspepsia <i>and</i> Q11 = pain				
Dysmotility Dyspepsia	Functional dyspepsia <i>and</i> Q11 = non-painful discomfort				
Aerophagia	Q15 = Yes	Q16 = Yes			
Functional Vomiting	Q17 = Yes	Q18 = No	Q19 = No	Q3 = No	

Bowel Disorders

Irritable Bowel Syndrome (IBS)	Q20 = Yes, + 2 of (Q21 or Q22 or Q23) = Yes†††
Diarrhea Predom. IBS	IBS + 1 or more of [Q24(2) or Q24(4) or Q24(6)], <i>and</i> none of [Q24(1) or Q24(3) or Q24(5)] <i>or</i> + 2 or more of [Q24(2) or Q24(4) or Q24(6)] <i>and</i> not more than 1 of [Q24(1) or Q24(5)] <i>and</i> Q24(3) = No

*Gastroesophageal reflux must be excluded.

†Note, functional heartburn and functional dysphagia are mutually exclusive in the suggested algorithms. It is important to note that if both are present, neither will show up in the data.

††Some of the editors prefer that 2 or more of [Q13 = Yes; Q14a = Yes; Q14b = Yes] (i.e., full criteria for IBS) are needed to exclude these upper abdominal symptoms from the category of Functional Dyspepsia.

†††Respondents who do not fulfill these criteria but who endorse Q10 = Yes, + 2 of (Q13 or Q14a or Q14b) = Yes should also be considered to have IBS.

Codes for Rome II Modular Questionnaire (cont'd)

Constipation Predom. IBS	IBS + 1 or more of [Q24(1) or Q24(3) or Q24(5)] <i>and</i> none of [Q24(2) or Q24(4) or Q24(6)] <i>or</i> + 2 or more of [Q24(1) or Q24(3) or Q24(5)], <i>and</i> not more than 1 of [Q24(2) or Q24(4) or Q24(6)]
Functional Abdominal Bloating	Q24(9), excluding IBS and Dyspepsia
Functional Constipation	Two or more of [Q24(1), Q24(3), Q24(5), Q24(7), Q24(10), Q24(11)] = Yes, and Q24(4) = No, excluding IBS
Functional Diarrhea	Q25 = Yes, Q10 = No, Q20 = No
Unspecified Functional Bowel Disorder	Bowel symptoms, but not sufficient to diagnose any other functional bowel disorder
Functional Abdominal Pain	
Functional Abdominal Pain Syndrome	Q26 = Yes <i>and</i> Q27 = Yes, excluding IBS/dyspepsia
Unspecified Functional Abdominal Pain	Q26 = Yes <i>and</i> Q27 = No, excluding IBS/dyspepsia or fails to meet full criteria
Biliary Disorders	
Gallbladder Dysfunction	Q28 = Yes <i>and</i> Q29 = Yes, Q30 = Yes <i>and</i> Q31 = No Q21 = No, Q22 = No, Q23 = No, [Q12 = 4 (only if Q10 = Yes and Q11 = Discomfort)]
Sphincter of Oddi Dysfunction	Q28 = Yes <i>and</i> Q29 = Yes <i>and</i> Q30 = Yes <i>and</i> Q31 = Yes <i>and</i> Q32 = Yes Q21 = No, Q22 = No, Q23 = No, [Q12 = 4 (only if Q10 = Yes and Q11 = Discomfort)]

Codes for Rome II Modular Questionnaire (cont'd)

Anorectal Disorders

Functional Incontinence	Q33 = Yes
Soiling	Q33 = Yes <i>and</i> Q34 = 1
Gross Incontinence	Q33 = Yes <i>and</i> Q34 = 2
Functional Anorectal pain	
Levator Ani Syndrome	Q35 = Yes Q36 = Yes Q37 = 2
Proctalgia Fugax	Q35 = Yes Q37 = 1
Pelvic Floor Dyssynergia	Functional Constipation + all of [Q38(1) + Q38(2) + Q38(3)]