Advanced Urogynecologic Care- Return Hemorrhoid Questionnaire:

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

PCP/Location: _____

Preferred Pharmacy: _____ Town/Zip Code: _____

What problem are you here for today? _____

MEDICATIONS:
Please list any medications **changes:** (including hormones, contraceptives, vitamins)
_____
_____
_____
_____
_____

ALLERGIES:
Do you have any **new** drug allergies? □ Yes □ No
Please list which drugs you are allergic to and what happens when you take them:

Please list any **new** medical problems or surgeries since the last visit:
_____
_____

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1. What is the primary reason for your visit?
   □ hemorrhoids □ rectal itching □ piles □ rectal bleeding □ fissures □ rectal swelling
   □ skin tags □ rectal pain □ other_____

2. What symptoms are you having?

   □ pain □ itching □ bleeding □ external tissue □ other_____

3. What treatment are you currently using? _____

4. How much time do you spend on the toilet at one time?
   □ less than 5 min. □ 5-10 min. □ more than 10 min.
5. Are you currently constipated? □ Yes □ No

GENERAL REVIEW OF SYMPTOMS
Please check if you've recently had any of the following:

□Fever or chills	□ Shortness of breath	□ Rashes
□ Headache	□ Heartburn	□ Loss of balance
□ Blurred vision	□ Blood in Stool	□ Anxiety
□ Chest pain	□ Muscle aches/pain	
□ Easy bruising/bleeding	□ UTI symptoms	
□ Vaginal bleeding	□ Blood in urine	