Advanced Urogynecologic Care- Hemorrhoid Intake Questionnaire:

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

Preferred Pharmacy: Name _____ City/Zip _____

Your Primary Care Physician:
Name: _____
Address: _____
_____
Fax: _____

Your Gynecologist:
Name: _____
Address: _____
_____
Fax: _____

Preferred Pharmacy: _____ Zip Code: _____

Prior patient of Dr. Tomezsko? Yes/No **(circle one)**

What problem are you here for today? _____

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

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

MEDICAL HISTORY:
As an adult have you had any of the following (check all that apply)?

- Glaucoma
- High Blood Pressure
- Heart Disease
- High Cholesterol
- Blood Clots/ Bleeding disorders
- Lung Problems
- Liver Disease
- GERD/Reflux
- Bowel Incontinence
- Constipation
- Irritable Bowel Syndrome (IBS)
- Blood in the urine
- Bladder Infections
- Interstitial Cystitis
- Kidney Disease
- Kidney or Bladder Stones
- Back Problems/ Spinal stenosis
- Arthritis
- Fibromyalgia
- Breast Cancer
- Stroke
- Dementia
- Sleep Apnea
- Multiple Sclerosis
- Parkinson's Disease
- Anxiety/Depression
- Diabetes
- Hypothyroid
- Pelvic Pain
- Fibroids
- Abnormal Pap Smear
- Endometriosis
- Painful Periods
- Postmenopausal Bleeding

Other Cancer_____
Any other medical conditions not listed above? Please list here: _____
_____
_____
_____
_____
_____

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OBSTETRICAL HISTORY

Number of Pregnancies_____
Number of Live Births_____
Number of Vaginal Deliveries_____
Number of Cesarean Sections_____

SURGICAL HISTORY

If you are over the age of 50, have you had a colonoscopy in the past 5 years? Yes or No **(circle one)**

Have you had a Hysterectomy? Yes or No (**circle one)**

If yes: which hospital and when? _____
For what reason? (*e.g., "fibroids, bleeding, prolapse"*): _____
What type?
Vaginal Hysterectomy/ Abdominal Hysterectomy/ Laparoscopic or Robotic Hysterectomy **(Circle one)**

Have you had your ovaries removed? Yes or No **(circle one)**

Have you had previous surgery for urinary incontinence? Yes or No **(circle one)**

If yes: which hospital and when? _____ _____
What type? Sling procedure/ Needle Suspension/ Burch of MMK/ Urethral Injection **(circle one)**

Have you had any previous surgery for pelvic relaxation/prolapse? Yes or No **(circle one)**

If so: which and when? _____
What type? Vaginal incision/ Abdominal incision/ Laparoscopic or robotic **(circle one)**

List and other operations or surgeries, and the year performed:

_____

_____

_____

FAMILY & SOCIAL HISTORY

Have any first-degree relatives had these diseases? If so, please indication their relationship

Ovarian Cancer: _____
Breast Cancer: _____
Other Cancer (list type): _____
Heart Disease: _____
Kidney Disease: _____
Blood/ Clotting Disorder: _____
Other Family Diseases: _____

Do you smoke? No/ Yes/ Prior Smoker (Circle one)
Do you drink alcohol? No/ Yes- Type: _____ How often? _____
Are you sexually active? Yes or No
Are you currently married? Yes or No

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GENERAL REVIEW OF SYMPTOMS

Please check if you've recently had any of the following:

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

HEMORRHOID QUESTIONS:

Latex Allergies? Y/N **Blood Thinners?** Y/N **Pregnant?** Y/N **Breast Feeding?** Y/N

1. Primary reason for your visit?

a. Hemorrhoids b. rectal itching c. piles d. rectal bleeding e. fissures
f. rectal swelling g. skin tags h. rectal pain i. other_____

2. What symptoms are you having?

a. pain b. itching c. bleeding d. external tissue e. other: _____

3. How long have your symptoms been present?

_____ Days _____Weeks _____ Months _____ Years

4. How severe are the symptoms on a scale of 1-10, 10 being the most severe? _____

5. What triggers these symptoms? (Circle all that apply)

a. bowel movements b. exercise c. sitting d. spicy foods e. standing f. straining g. straining
e. other: _____

6. Have you had any previous hemorrhoid treatment? (Circle all that apply)

a. injection b. drainage of blood clot c. banding d. IRC (infrared coagulation) e. PPH f. hemorrhoidectomy e. none
Date & success of treatment: _____

7. Are you using over the counter medications? (Circle all that apply)

a. aspirin b. suppositories c. hemorrhoid cream d. fiber supplement e. laxative f. probiotics g. Preparation H h. MiraLAX i. none

8. Have you had any of the following?

a. Barium enema b. X-ray c. CT Abdomen d. series e. Sigmoidoscopy f. colonoscopy g. Upper GI h. none
Procedure finding & Date: _____

9. Have you ever been diagnosed with:

a. Hepatitis A b. AIDS c. Hepatitis B d. genital herpes e. Hepatitis C f. anal warts g. HIV h. tuberculosis i. none

10. How much time do you spend on the toilet at one time?

a. less than 5 minutes b. 5-10 minutes c. more than 10 minutes

11. Are you currently constipated?

a. Yes b. No

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