Advanced Urogynecologic Care - Hemorrhoid Intake Questionnaire:

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

Preferred Pharmacy: _____ Zip Code: _____Your

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

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

Who referred you to Dr. Tomezsko? _____

Dr. Tomezsko's previous patient? Yes/No **(circle it)**

What problem are you here for today? _____

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

ALLERGIES:
Are you allergic to medications? □ Yes □ No
Please list which medications you are allergic to and what happens when you take them:

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

- □ Glaucoma
- □ High Blood Pressure
- □ Cardiovascular diseases
- □ High cholesterol
- □ Blood Clots/Bleeding Disorders
- □ Lung problems
- □ Liver Diseases
- □ GERD/Reflux
- □ Intestinal 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
- □ Blow
- □ Dementia
- □ Sleep apnea
- □ Multiple Sclerosis
- □ Parkinson
- □ Anxiety/Depression
- □ Diabetes
- □ Hypothyroidism
- □ Pelvic pain
- □ Myoma
- □ Abnormal Pap smear
- □ Endometriosis
- □ Painful periods
- □ Postmenopausal bleeding

Other Cancer_____

Do you have any other medical conditions not listed above? Please list here:
_____
_____
_____

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OBSTETRIC HISTORY

Number of Pregnancies_____
Number of living Births_____
Number of vaginal Deliveries_____
Number of caesarean Sections_____

SURGICAL HISTORY

If you are over the age of 45, have you had a colonoscopy in the last 5 years? Yes or No **(circle it)**

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

If so, in 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 surgery for urinary incontinence before? Yes or No **(circle it)**

If so, in which hospital and when? _____ _____

What type? Sling Treatment / Needle Suspension / Birch MMK / Urethral Injection **(Circle)**

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

If so, which ones and when? _____
What type?

Vaginal Incision / Abdominal Incision / Laparoscopic or Robotic **(Circle One)**

List and other operations or operations, as well as the year of conduct:

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FAMILY AND SOCIAL HISTORY

Did any of the first-degree relatives have these diseases? If yes, please indicate their relationship.
Ovarian cancer: _____
Breast Cancer: _____
Other Cancers (list type): _____
Cardiovascular diseases: _____
Kidney disease: _____
Bleeding disorders: _____
Other familial diseases: _____

Do you smoke? No/ Yes/ 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

OVERVIEW OF SYMPTOMS

Please check to see if you have had any of the following recently:

□Fever or chills
□ Headache
□ Blurred vision
□ Easy bruising/bleeding
□ Bread in the Chest
□ Shortness of breath
□ Heartburn
□ Vaginal bleeding
□ Symptoms of UTIs
□ Blood in the stool
□ Muscle pain
□ Loss of balance
□ Rash

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QUESTIONS ABOUT HEMORRHOIDS:

Latex allergy? Y/N **Blood thinners?** Y/N **Are you pregnant?** Y/N **Breastfeeding?** Y/N

1. What is the main reason for your visit?

- ☐ Hemorrhoids
- ☐ rectal pruritus
- ☐ piles
- ☐ rectal bleeding
- ☐ fissures
- ☐ Rectal edema
- ☐ G. Papilloma's on the skin
- ☐ H. Rectal pain
- ☐ Other_____

2. What symptoms do you have?

- ☐ pain
- ☐ pruritus
- ☐ bleeding
- ☐ external tissues
- ☐ other: _____

3. How long have your symptoms been present? _____ days _____Weeks _____ months _____ years

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

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

- ☐ Bowel movements
- ☐ Exercise
- ☐ Sitting
- ☐ Spicy foods
- ☐ Standing
- ☐ Straining
- ☐ Other: _____

6. Have you had any treatment for hemorrhoids before? (Check all that apply)

- ☐ injection
- ☐ blood clot drainage
- ☐ banding
- ☐ IRC (infrared coagulation)
- ☐ PPH
- ☐ hemorrhoidectomy
- ☐ None

Date and success of treatment: _____

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7. Do you take over-the-counter medications? (Circle all that apply)

- Aspirin
- Suppositories
- Hemorrhoid cream
- Fiber supplement
- Laxative
- Probiotics
- Preparation H
- MiraLAX
- none

8. Have you had any of the following?

- a. Barium enema
- X-ray
- CT scan of the abdomen series
- sigmoidoscopy
- colonoscopy Upper GI
- None

Procedure and date: _____

9. Have you ever been diagnosed:

- Hepatitis A
- AIDS
- Hepatitis B
- genital herpes
- Hepatitis C
- anal warts
- HIV
- tuberculosis
- none

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

- less than 5 minutes
- 5-10 minutes
- more than 10 minutes

11. Do you currently suffer from constipation?

- Yes
- No

For Medical Assistant ONLY

→□ Flowsheets □ Med Hx □ Meds/Allergies □ PVR/Dip □ Consent □ Vitals

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