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/ 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

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

□ Fever or chills	□ Shortness of Breath	□ Loss Of Balance
□ Headache	□ Heartburn	□ Anxiety
□ Blurred vision	□ Blood in Stool	□ Vaginal Bleeding
□ Chest pain	□ Muscle aches and pain	□ UTI symptoms
□ Easy bruising/bleeding	□ Rash	□ Blood in Urine

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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 itching
- ☐ piles
- ☐ rectal bleeding
- ☐ fissures
- ☐ Rectal edema
- ☐ G. Papilloma's on the skin
- ☐ H. Rectal pain
- ☐ Other___________

2. What symptoms do you have?

- ☐ pain
- ☐ itching
- ☐ 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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