

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)?

- | | | |
|---|--|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Parkinson |
| <input type="checkbox"/> Cardiovascular diseases | <input type="checkbox"/> Interstitial cystitis | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood Clots/Bleeding Disorders | <input type="checkbox"/> Kidney or bladder stones | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Back Problems / Spinal Stenosis | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Liver Diseases | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Myoma |
| <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Abnormal Pap smear |
| <input type="checkbox"/> Intestinal incontinence | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Blow | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Irritable bowel syndrome (IBS) | <input type="checkbox"/> Dementia | <input type="checkbox"/> Postmenopausal bleeding |
| | <input type="checkbox"/> Sleep apnea | |

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Vaginal Bleeding |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Muscle aches and pain | <input type="checkbox"/> UTI symptoms |
| <input type="checkbox"/> Easy bruising/bleeding | <input type="checkbox"/> Rash | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urinary leakage | | |

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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

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Date and success of treatment: _____

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 → <input type="checkbox"/> Flowsheets <input type="checkbox"/> Med Hx <input type="checkbox"/> Meds/Allergies <input type="checkbox"/> PVR/Dip <input type="checkbox"/> Consent <input type="checkbox"/> Vitals
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