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	□ 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
□ Urinary Leakage		

For Medical Assistant ONLY
→□ Flowsheets □ Med Hx □ Meds/Allergies □ PVR/Dip □ Consent □ Vitals