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
- □ Stroke
- □ Arthritis
- □ Fibromyalgia
- □ Breast Cancer
- □ 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

Have you ever had a colonoscopy? ☐ **Yes:** When? _____ ☐ **No**

Have you had a hysterectomy? ☐ **Yes** ☐ **No**

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
□ Urinary leakage		

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QUESTIONS ABOUT HEMORRHOIDS:

1. Latex allergy? Y/N **2. Blood thinners?** Y/N **3. Are you pregnant?** Y/N **4. Breastfeeding?** Y/N

5. 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_____

6. What symptoms do you have?

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

7. How long have your symptoms been present? _____days _____Weeks _____ months _____ years

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

9. What causes these symptoms?

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

10. 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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11**. Do you take over-the-counter medications?**

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

12. Have you had any of the following?

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

Procedure and date: _____

13. Have you ever been diagnosed:

- □ Hepatitis A
- □ AIDS
- □ Hepatitis B
- □ genital herpes
- □ Hepatitis C
- □ Anal Warts
- □ HIV
- □ tuberculosis
- □ none

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

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

15. Do you currently suffer from constipation?

☐ Yes ☐ No

For Medical Assistant ONLY

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