

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

Other Cancer _____

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

OBSTETRIC HISTORY

Number of Pregnancies _____

Number of living Births _____

Number of vaginal Deliveries _____

Number of caesarean Sections _____

SURGICAL HISTORY

Date of last colonoscopy: _____

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:

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 | | |

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 | ☐ PPH |
| ☐ blood clot drainage | ☐ hemorrhoidectomy |
| ☐ Banding | ☐ None |
| ☐ IRC (infrared coagulation) | |

Date and success of treatment: _____

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
- ☐ Date of last 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