Hemorrhoid Consultation

NAME:_____
DATE:_____

Date of Birth:_____ AGE:_____ WEIGHT:_____

HEIGHT:_____ MALE / FEMALE

Primary Care
Physician:_____

Please list Current Medications
w/dosage:_____

_____

Please list all known
Allergies:_____

Do you smoke? YES ____ / NO ____ (If yes, packs per day _____)

Currently Pregnant? YES ____ / NO ____ Number of pregnancies _____

Please list past medical
surgeries:_____

PLEASE CHECK ALL CURRENT SYMPTOMS:

- BRIGHT RED BLEEDING
- ITCHING
- DULL PAIN
- SHARP PAIN
- PROTRUSION
- SPOTTING
- IRRITATION
- CONSTIPATION
- DIARRHEA
- ANAL FULLNESS
- OTHER: _____

Do symptoms only occur after a bowel movement or strenuous physical activity? YES ____ / NO ____

Is it difficult to sit for prolonged periods of time? YES ____ / NO ____

Are bowel movements a daily occurrence, if so typically how many? _____

Is your daily fiber intake less than or equal to 25grams per day? LESS _____ / AVERAGE _____

Do you feel you drink enough fluids throughout the day? YES ____ / NO ____

PLEASE TURN PAGE OVER TO COMPLETE FORM ⟶

Hemorrhoid Consultation

Have you ever had a Colonoscopy? YES ____ / NO ____ DATE:_____
Were any polyps observed? YES ____ / NO ____

Currently taking any blood thinning medications? YES ____ / NO ____

Any recent weight loss/fevers/chills/sweats? YES ____ / NO ____ Please specify:_____
_____

Family Cancer History (please check & list relationship)

- Colon: _____
- Rectal: _____
- Breast: _____
- Uterine: _____
- Other: _____

Have you had previous medical hemorrhoid treatment? YES ____ / NO ____ Please

Specify:_____

_____

Are you currently taking any medications for hemorrhoids including over the counter medications?

YES ____ / NO ____ Please specify:_____

FOR CLINICAL STAFF BEYOND THIS POINT

Patient BP: _____ Patient to return to office in:_____

Medications prescribed w/instructions:_____
_____

PLEASE TURN PAGE OVER TO COMPLETE FORM ⟶