

Hemorrhoid History Form

Patient Name: _____

Today's Date: _____

1. **What is the reason for today's visit?** _____

2. **Do you experience any of the following symptoms?**

Pain or burning with bowel movements?

Is the pain constant? Yes No Is the pain only with bowel movements? Yes No

Fevers or chills with rectal pain?

Blood on the tissue paper when wiping or in the toilet bowl after a bowel movement?

Anal itching?

Difficulty or changes in bowel movements (diarrhea or constipation)?

Tissue protrusion around the anus?

3. **Have you been treated for any of the following rectal problems in the past?**

Anal fissure

Anal fistula

Rectal prolapse

Hemorrhoids

Perirectal Abscess

Anal warts or condylomas

4. **Do you use any regular fiber supplements?** Yes No

5. **Have you had a previous colonoscopy?** Yes No

When and where? _____

What were the findings? _____

6. **What relieves your symptoms?** _____