Hemorrhoid History Form

Patient Name: _____ Today's Date: _____

1. Reason for today's visit :_____
2. Have you ever experienced any of the following…

   ☐ Straining to have a bowel movement

   ☐ Blood on the tissue paper

   ☐ Blood in the toilet bowl

   ☐ Constipation

   ☐ Rectal Pain

   _____ is it constant pain?

   _____ is the pain only with bowel movements?

3. Have you had any of the following rectal problems in the past?

   ☐ Fissure ☐ Fistula

   ☐ Hemorrhoids ☐ Abscess

4. Do you use regular fiber supplements? ☐ Yes ☐ No
5. Is there anything that relives your symptoms? ☐ Yes ☐ No

   a. If yes, what helps? _____

6. Do you experience fevers or chills with rectal pain? ☐ Yes ☐ No