HEMORRHOID
TREATMENT CENTER
of Orange County

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www.ochemorrhoids.com

Name: ..... Date: .....

Patient Questionnaire – Anorectal Health

Bowel & Dietary Habits

(Circle either Yes or No for each answer)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea? **Y / N**
3. Do you have to strain or push hard when having a bowel movement? **Y / N**
4. Time spent on toilet during average bowel movement? Minutes
5. Does any tissue ever come out of your rectum (prolapse) during a bowel movement? **Y / N**
6. Do you often feel like you're "still not done" after a bowel movement? **Y / N**
7. Are you taking any fiber supplements? **Y / N**

a. If yes, which one(s)? .....

8. On average, do you drink the equivalent of 6-8 glasses of water per day? **Y / N**

Symptoms (in Rectal Area)

(Check all that apply)

☐ Bleeding ☐ Itching ☐ Prolapse ☐ Pressure or Swelling ☐ Leaking or Soiling ☐ Pain ☐ Burning

Additional Questions

(Circle either Yes or No for each answer)

1. Are you allergic to latex? **Y / N**
2. Are you pregnant? **Y / N**
3. Are you taking any blood thinners (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.)? **Y / N**
4. Have you ever been diagnosed with Crohn's disease, proctitis, cirrhosis or anal/rectal cancer? **Y / N**
5. Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**
6. Have you ever had a colonoscopy? **Y / N** Date of last colonoscopy: .....

Additional Comments?

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Please return by e-mail before your appointment to **drjaydiliberto@gmail.com**