Hemorrhoid Centers of America

Today's Date:_____ **Pt Initials:** _____

PATIENT INFORMATION

First Name:	Last Name:	Middle Name:
Suffix:	Nickname:	☐Male ☐Female

Date of Birth:	Social Security #:	Preferred Language:

Race: ☐Asian ☐Native Hawaiian ☐Other ☐Pacific Islander ☐ Black / African American (not Hispanic or Latino) ☐American Indian/Alaska Native ☐White (not Hispanic or Latino) ☐Hispanic or Latino (all races) ☐Decline to answer

Home Phone:	Cell Phone:	Work Phone:

Email Address:

Street Address:

Zip Code:	State:	City:

Emergency Contact:	Contact Phone:	Contact Relation:

How did you hear about us? ☐internet ☐Google ☐Yahoo ☐Facebook ☐physician ☐relative ☐friend ☐patient ☐insurance company website ☐print ad ☐television ad ☐other:

Referral Source: Physician Name: Physician Phone Number:

May we leave a message for you? ☐at home ☐on your cell ☐at work

May we discuss your medical care with? ☐Spouse ☐Mother ☐Father ☐Son ☐Daughter ☐Caregiver ☐Friend ☐Other ☐None _____

Are you currently in hospice? ☐YES ☐NO

Primary Care Physician Information

Keeping your primary care physician aware of all medical procedures is an important part of your medical history. Would you like us to notify your primary care physician of your treatments? ☐No ☐Yes If yes, please provide the following information for your PCP and complete the attached authorization of medical records release form.

Primary Care Physician:	PCP Phone Number:

PCP Street Address:

Zip Code:	State:	City:

PCP Fax Number:	

Guarantor Information (person responsible for the bill) If different than the patient				
Last Name:	First Name:	Middle Initial:	Relationship to patient:	
Address:	City:	State:	Zip Code:	
Home Phone Number:	Cell Phone Number:			
Social Security #:	Date of Birth:			
Employer:	Emp. Address:	City:	State:	Zip Code:
Employer Phone Number:	Ext:			

(check ✓ if applicable)

- ☐ I have read and received a copy of the Notice of Privacy Practices.
- ☐ I certify that the information provided is correct.

_____
Patient / Guarantor Signature / *Parent or Legal Guardian (if pt. is under the age of 18)

_____
Date

Medical Information

1: Please list any current medications:

Active Medications:	
Med & Dosage	Indication

2. Please list any allergies:

Active Allergies	
Allergy	Reaction

3. Please list ongoing medical conditions:

Ongoing Medical Conditions		
Problem	Date Diagnosed	Status

Please check those that apply.

4. What is the primary reason for your visit? ☐Hemorrhoids ☐piles ☐fissure ☐skin tag ☐rectal pain ☐rectal itching ☐rectal bleeding ☐rectal swelling ☐other _____

5. What symptoms are you having? ☐pain ☐bleeding ☐external tissue ☐itching ☐other_____

6. How long have the symptoms been present for: _____days _____ weeks _____months _____ years

7. How severe are these symptoms on a scale of 1-10, 10 being the most severe? _____

8. What triggers these symptoms? ☐bowel movement ☐sitting ☐standing ☐straining ☐exercise ☐spicy foods ☐diarrhea ☐constipation ☐other_____

9. Has your weight changed? ☐gained weight ☐lost weight ☐stayed the same

10. **Are you allergic to latex?** ☐Yes ☐No

11. **If you're female, are you pregnant?** ☐pregnant ☐possibly pregnant ☐not pregnant

12. Have you had any previous hemorrhoid treatment? ☐injections ☐hemorrhoidectomy ☐PPH ☐IRC - infrared coagulation ☐banding ☐drainage of blood clot ☐none ☐other _____
Date and success of treatment: _____

13. Are you using any over the counter medications? ☐Aspirin ☐fiber supplements ☐laxatives ☐Preparation H ☐suppositories ☐hemorrhoid cream ☐probiotics ☐Miralax ☐none ☐other_____
Frequency and dose of over the counter medications: _____

14. Have you had any of the following: ☐Barium Enema ☐CT scan of abdomen ☐sigmoidoscopy ☐upper GI ☐Xray ☐series ☐colonoscopy ☐none
Procedure findings and date: _____

15. Have you been diagnosed with cancer? ☐Yes ☐No
Please List: _____

16. Have you ever been diagnosed with: ☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐HIV ☐AIDS ☐genital herpes ☐anal warts ☐tuberculosis ☐none ☐other _____

17. Have you ever had **Gastrointestinal** Issues? ☐abdominal pain ☐anal fissure ☐black & tarry stools ☐bowel obstruction ☐constipation ☐Crohn's disease ☐diarrhea ☐diverticulitis / diverticulosis jaundice / cirrhosis ☐hemorrhoids ☐incontinence or soiling ☐intestinal tumor (neoplasm) ☐nausea or vomiting ☐perianal rash ☐polyps ☐rectal prolapsing tissue ☐Ulcerative Colitis ☐vomiting blood ☐none

18. Have you ever had any **Cardiovascular** issues? ☐chest pain ☐hypertension ☐heart disease ☐mitral valve prolapse ☐implants ☐none ☐other _____

19. Have you ever had **Genitourinary** issues? ☐urine retention ☐painful urination ☐frequent urination ☐urinary tract infections

20. Have you ever had any **Constitutional** symptoms? ☐fever ☐chills ☐headaches or migraines

21. Have you ever had any **Endocrine** issues? ☐excessive thirst ☐too hot ☐too cold ☐tired or sluggish ☐diabetes

22. Have you ever had **Neurological** symptoms? ☐tremors ☐dizzy spells ☐numbness or tingling ☐stroke ☐epilepsy

23. Have you ever had **Respiratory** problems? ☐asthma ☐frequent cough ☐shortness of breath

24. Have you ever had **Hematologic/Lymphatic** problems? ☐swollen glands ☐blood clotting disorder ☐anemia

25. **Eye** problems? ☐blurred vision ☐double vision ☐vision changes ☐pain

26. **Integumentary** (skin/breast) issues? ☐skin rash ☐boils ☐persistent itch

27. **Ear/Nose/Throat/Mouth** symptoms? ☐ear infection ☐soar throat ☐sinus problems

28. **Musculoskeletal problems?** ☐arthritis ☐neck pain ☐back pain

29. **Psychiatric** issues? ☐depression ☐anxiety ☐history of pain none

30. How much water do you drink in a day? ☐less than one 8 oz glass ☐one 8 oz glass ☐2-3 8 oz glasses ☐4-6 8 oz glasses ☐7-8 oz glasses ☐8 + 8 oz glasses

31. How much time do you spend on the toilet at one time? ☐less than 5 min. ☐5-10 min. ☐more than 10 min.

Social History

32. Do you drink alcohol? ☐never ☐occasionally ☐frequently ☐other_____

33. Do you smoke cigarettes? ☐current every day smoker ☐current some day smoker ☐former smoker ☐never smoker

34. Do you use recreational drugs? ☐never ☐occasionally ☐frequently ☐other _____

35. Do you participate in receptive anal sex? ☐Never ☐occasionally ☐frequently

36. Marital Status: ☐single ☐married ☐not married ☐divorced ☐widowed ☐ domestic partnership ☐civil union

Family Medical History

37. Have any of your family members been diagnosed with? ☐hemorrhoids ☐fissures ☐colon polyps or tumors ☐stroke ☐heart disease ☐diabetes ☐cancer ☐none ☐other _____
List relatives with diagnosis: _____