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Hemorrhoidal Consult Questionnaire

Patient Name: _____ **Date:** _____
DOB: _____ **Provider:** _____

Chief Complaint & History of Present Illness (HPI)

Please check or fill in all that apply.

☐ What symptoms are you currently experiencing?

_____

☐ Duration of symptoms: _____

☐ Hemorrhoids are: ☐ Internal ☐ External ☐ Both

☐ Severity of bleeding: ☐ Mild (streaks on stool) ☐ Moderate (dripping) ☐ Severe (fills toilet bowl)

☐ Do you experience prolapse (tissue protrusion) during bowel movements? ☐ Yes ☐ No

☐ Do you have: ☐ Pain ☐ Itching ☐ Burning ☐ None

☐ Do symptoms worsen with straining or sitting for long periods? ☐ Yes ☐ No

☐ Any changes in bowel habits? ☐ Constipation ☐ Diarrhea ☐ None

☐ Difficulty controlling bowel movements or leakage? ☐ Yes ☐ No

☐ Average bowel movements per week: _____

Prior Treatments

☐ Have you tried any of the following conservative measures?

☐ Fiber ☐ Stool softeners ☐ Hydration ☐ Topical creams ☐ Sitz baths

☐ Any prior hemorrhoid procedures? ☐ Yes ☐ No

If yes, specify type and date: _____

Results: _____

☐ Have you used any over-the-counter or prescription medications for hemorrhoids? ☐ Yes ☐ No

If yes, which ones? _____

☐ Any prior interventional radiology or embolization procedures? ☐ Yes ☐ No
If yes, specify: _____

Bleeding & Impact on Quality of Life

☐ How often do you experience rectal bleeding? _____
☐ When was your last episode? _____
☐ Does bleeding occur with every bowel movement? ☐ Yes ☐ No
☐ Have you experienced: ☐ Dizziness ☐ Fatigue ☐ Symptoms of anemia
☐ Has bleeding limited your work or activities? ☐ Yes ☐ No
☐ Have you needed blood transfusions or iron supplements? ☐ Yes ☐ No

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Pain Assessment

☐ Rate your rectal pain (0 = none, 10 = worst): _____/10
☐ Pain occurs: ☐ Constant ☐ Only during bowel movements
☐ Does pain interfere with sleep or daily activities? ☐ Yes ☐ No
☐ What do you take for pain relief? _____

Medication Review

☐ List all current medications and supplements:

☐ Any recent medication changes? ☐ Yes ☐ No
☐ Herbal or over-the-counter products for constipation or hemorrhoids? ☐ Yes ☐ No
If yes, specify: _____

Functional & Lifestyle Questions

☐ How is this condition affecting your daily life? _____
☐ How would you describe your diet? ☐ High fiber ☐ Moderate ☐ Low fiber
☐ Daily water intake (approx.): _____ cups
☐ Do you exercise regularly? ☐ Yes ☐ No Type: _____
☐ Do you spend long periods sitting (e.g., at work or driving)? ☐ Yes ☐ No
☐ Do you smoke? ☐ Yes ☐ No ☐ Drink alcohol? ☐ Yes ☐ No

Additional Notes or Concerns:

Patient Signature: _____ Date: _____