

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)

- | | | |
|-----------------------------------------------|---------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Itching | <input type="checkbox"/> Prolapse |
| <input type="checkbox"/> Pressure or Swelling | <input type="checkbox"/> Leaking or Soiling | <input type="checkbox"/> Pain <input type="checkbox"/> 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 erectile dysfunction medicine for ED, any Viagra for hypertension, Cialis for your prostate or any nitrates for chest pain? **Y / N**
4. Are you taking any blood thinners or anticoagulation medication (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.)? **Y / N**
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? **Y / N**
6. Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**
7. Do you need to take antibiotics before having dental or other procedures? **Y / N**

Additional Comments?
