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**
	1. If yes, which one(s)?
8. On average, do you drink the equivalent of 6-8 glasses of water per day? **Y / N**
9. Are you taking prescription pain pills? **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 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?**