

PATIENTS NAME _____ SINGLE _____
ADDRESS _____ MARRIED _____
CITY/STATE _____ ZIP _____ OTHER _____
HOME PHONE _____ MALE _____ FEMALE _____
YOUR SS# _____ BIRTH DATE _____ AGE _____
EMPLOYED: YES _____ NO _____ EMPLOYER'S NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE NUMBER _____

YOUR SYMPTOMS

WHEN DID PRESENT TROUBLE START? _____

HAVE YOU EVER HAD THIS PROBLEM BEFORE? _____

DO YOU HAVE ANY RECTAL BLEEDING? _____ PROTRUSION? _____

PAIN? _____ ITCHING? _____ DISCHARGE? _____

DO YOU HAVE A PROBLEM WITH CONSTIPATION? _____

NUMBER OF BOWEL MOVEMENTS DAILY? _____

HAVE YOU EVER HAD:

DIABETES? _____ HIGH BLOOD PRESSURE? _____ CANCER? _____ ANEMIA? _____ VENEREAL DISEASE? _____

CHEST PAIN? _____ PACEMAKER? _____ ABNORMAL HEART RATE? _____

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING?

ARE YOU ALLERGIC TO ANY PRESCRIPTIVE MEDICATIONS?

FOR WOMAN ONLY:

DATE OF LAST PERIOD? _____ LAST PAP SMEAR? _____

NUMBER OF PREGNANCIES? _____

COMPLICATIONS DURING BIRTH? _____