Suffolk Surgical Associates, P.C.
Call: (631) 665-8200
Patient Questionnaire

Bowel & Dietary Habits

(Circle All That Apply)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea? **Y / N**
3. Do you have to strain when having a bowel movement? **Y / N**
4. Do you ever feel like you're "still not done" after a bowel movement? **Y / N**
5. Time spent on toilet during average bowel movement? _____Minutes
6. Does any tissue ever poke out of your rectum during a bowel movement? **Y / N**
    a. If so, does the tissue **go back by itself** or do you have to **push it back in**?
7. Are you taking any fiber supplements? **Y / N**
    a. If yes, which ones? _____
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)

☐ Bleeding	☐ Itching	☐ Burning
☐ Pressure	☐ Pain	☐ Leaking or Soiling

Additional Questions

(Circle All That Apply)

1. Are you allergic to latex? **Y / N**
2. Are you pregnant? **Y / N**
3. Are you taking any erectile dysfunction medicine or any nitrates for chest pain? **Y / N**
4. Are you taking any anticoagulation medication (Coumadin, Plavix)? **Y / N**
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? **Y / N**

Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**

Additional Comments?

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