GEORGIA
HEMORRHOID INSTITUTE

Name (Last, First, M.I.):			☐ Male ☐ Female	**DOB:**	
Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
How did you hear about us?		☐ Doctor referral		☐ Friend / Family	
☐ Internet search		☐ Insurance plan		☐ Other	
Referring doctor:			**Primary Care Physician:**		
Orthopedist:			**Other doctor:**		
Pharmacy:			**Pharmacy Phone Number:**		

The following questions ask about your feelings and experiences regarding the impact of hemorrhoid bleeding symptoms on your life. Please consider each question as it relates to your experiences with hemorrhoid bleeding during the previous 3 months. There are no right or wrong answers. Please be sure to answer every question by checking the most appropriate box. If the question does not apply to you, please check "none of the time" as your option.

Hemorrhoid Bleeding Questionaire		
Variable	**Question**	**Score**
Frequency	Never	0
	Less than 1 per day or at each bowel movement	1
	Greater than or equal to 1 per day or at each bowel movement	2
Type	Never	0
	With wiping and / or in underwear	1
	In toilet bowl	2
Anemia	Never	0
	Iron deficiency without anemia	1
	Without transfusion	2
	With transfusion	3
Discomfort	Little or no discomfort	0
	Moderate discomfort	1
	Frank or permanent discomfort	2
Overall Score		

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During the previous 3 months, how often have your symptoms related to hemorrhoid bleeding:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Made you feel anxious about the unpredictable onset or duration of your bleeding?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Made you anxious about traveling?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Interfered with your physical activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Cause you to feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Made you decrease the amount of time you spent on exercise or other physical activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Made you feel as if you are not in control of your life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Made you concerned about soiling underclothes?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Made you feel less productive?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Caused you to feel drowsy or sleepy during the day?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Made you feel that it was difficult to carry out your usual activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. Interfered with your social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. Made you concerned about soiling bed linen?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. Made you feel sad, discouraged, or hopeless?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. Made you feel down-hearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. Made you feel wiped out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. Caused you to be concerned or worried about your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
17. Caused you to plan activities more carefully?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
18. Made you feel inconvenienced about always carrying extra supplies, and clothing for bleeding issues?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
19. Caused you embarrassment?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
20. Made you feel uncertain about your future?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
21. Made you feel irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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During the previous 3 months, how often have your symptoms related to hemorrhoid bleeding:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
22. Made you concerned about soiling outer clothes?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
23. Made you feel that you are not in control of your health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
24. Made you feel weak as if energy was drained from your body?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
25. Diminished your sexual desire?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
26. Caused you to avoid sexual relations?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5