

GEORGIA

HEMORRHOID INSTITUTE

Name (Last, First, M.I.):		<input type="checkbox"/> Male	DOB:		
		<input type="checkbox"/> Female			
Marital status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
How did you hear about us?		<input type="checkbox"/> Doctor referral		<input type="checkbox"/> Friend / Family	
<input type="checkbox"/> Internet search		<input type="checkbox"/> Insurance plan		<input type="checkbox"/> 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 Questionnaire		
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		

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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. Made you anxious about traveling?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. Interfered with your physical activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. Cause you to feel worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. Made you decrease the amount of time you spent on exercise or other physical activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. Made you feel as if you are not in control of your life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. Made you concerned about soiling underclothes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. Made you feel less productive?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. Caused you to feel drowsy or sleepy during the day?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Made you feel that it was difficult to carry out your usual activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Interfered with your social activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Made you concerned about soiling bed linen?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Made you feel sad, discouraged, or hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
14. Made you feel down-hearted and blue?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
15. Made you feel wiped out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
16. Caused you to be concerned or worried about your health?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
17. Caused you to plan activities more carefully?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
18. Made you feel inconvenienced about always carrying extra supplies, and clothing for bleeding issues?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
19. Caused you embarrassment?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
20. Made you feel uncertain about your future?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
21. Made you feel irritable?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23. Made you feel that you are not in control of your health?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
24. Made you feel weak as if energy was drained from your body?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
25. Diminished your sexual desire?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
26. Caused you to avoid sexual relations?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5