CAROLINA RHI

Patient Intake Form

Carolina Rectal Health Institute
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PATIENT INFORMATION

Full Name: _____
Date of Birth: _____ Age: _____
Gender: □ Male □ Female □ Other: _____
Address: _____
City/State/ZIP: _____
Phone: _____ Email: _____
Preferred Contact: □ Phone □ Text □ Email

Insurance Provider:_____

Referring Provider (if any): _____

Primary Care Provider: _____

What brings you in today?

_____

_____

Severity Pain score (0–10): _____/10
How long have you had these symptoms _____
Timing of symptoms (constant/intermittent): _____
Modifying factors: What makes it better or worse?

REVIEW OF SYSTEMS

Please check all that apply:

GENERAL

□ Fever □ Chills □ Weight loss □ Fatigue □ None

GASTROINTESTINAL

□ Rectal pain
□ Bleeding
□ Constipation
□ Diarrhea
□ Rectal pressure
□ Tissue prolapse
□ None

GENITOURINARY

□ Pain with urination
□ Increased frequency

□ Leakage / incontinence
□ None

SKIN

□ Rashes
□ Perianal irritation
□ None

NEUROLOGIC

□ Weakness
□ Numbness
□ None

HEMATOLOGIC

□ Easy bleeding
□ Easy bruising
□ On blood thinners
□ None

PSYCHIATRIC

□ Anxiety
□ Depression
□ None

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PAST MEDICAL HISTORY

(List all medical conditions)

_____

_____

PAST SURGICAL HISTORY

_____

_____

MEDICATIONS

(Include prescription, over-the-counter, vitamins, supplements)

_____

_____

Are you on a blood thinner?
□ No □ Yes → Which? _____

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ALLERGIES

□ No known allergies
□ Allergic to: _____

Reaction(s): _____

FAMILY HISTORY

Any family history of colorectal disease?
□ Colon cancer □ Polyps □ Crohn's □ Ulcerative colitis □ None
Other: _____

SOCIAL HISTORY

Tobacco: □ Never □ Former □ Current
Alcohol: □ None □ Social □ Daily

Occupation: _____

SYMPTOM-SPECIFIC QUESTIONS (ANORECTAL)

Bleeding: □ Bright red □ Dark □ On toilet paper □ In toilet bowl
Pain: □ Sharp □ Dull □ Itching □ Burning

Prolapse:
□ Tissue comes out □ Goes back in on its own
□ Must push it back □ Constantly out

Bowel habits:
Stool frequency per day/week: _____
Straining? □ Yes □ No
Sensation of incomplete emptying? □ Yes □ No

PRIOR TESTING / PROCEDURES

Colonoscopy:
□ Never
□ Yes Date: _____ Findings (if known): _____

Relevant imaging: _____

FOR PATIENT TO SIGN

I certify that the information provided is accurate to the best of my knowledge.

Patient Signature: _____
Date: _____