Patient Questionnaire - Banding

NAME:_____

DATE:_____

Bowel & Dietary Habits

(Circle either Yes or No for each answer)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea? **Y / N**
3. Do you have to strain or push hard when having a bowel movement? **Y / N**
4. Time spent on toilet during average bowel movement? _____Minutes
5. Does any tissue ever come out of your rectum (prolapse) during a bowel movement? **Y / N**
6. Do you often feel like you're "still not done" after a bowel movement? **Y / N**
7. Are you taking any fiber supplements? **Y / N**

a. If yes, which one(s)? _____

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	Prolapse	Burning
Pressure or Swelling	Leaking or Soiling	Pain	

Additional Questions

(Circle either Yes or No for each answer)

1. Are you allergic to latex? **Y / N**
2. Are you pregnant? **Y / N**
3. Are you taking any erectile dysfunction medicine for ED, any Viagra for hypertension, Cialis for your prostate or any nitrates for chest pain? **Y / N**
4. Are you taking any blood thinners or anticoagulation medication (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.)? **Y / N**
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? **Y / N**
6. Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**
7. Do you need to take antibiotics before having dental or other procedures? **Y / N**