Mr./Mrs. _____, age: _____, your appointment for proctological examinations is on _____ at _____ o'clock with. _____ MD.

At this hour or no less than 15 minutes before you check yourself to the reception office. The appointment indicates your administrative admission and not the treatment at the clinic

Please answer the following questions:

When did the problems start? _____

What kind of problems (circle around)?
- ☐ anal bleeding
- ☐ anal pain
- ☐ itching
- ☐ rectal prolapse/mucosa
- ☐ fecal incontinence

How many times do you defecate?
- ☐ multiple times a day
- ☐ 1 time a day
- ☐ few times a week

- ☐ hard
- ☐ mild
- ☐ soft
- ☐ liquid stool

Did any of the family member (mother, dad, aunt, sister) have polyps on the large intestine? ☐ no ☐ yes Who? _____

Did any of the family member (mother, dad, aunt, sister) have any other disease on the large intestine (ulcerative colitis, Mb Crohn)? ☐ no ☐ yes Who? _____

Have you had colonoscopy?

Bring your letter with you. ☐ no ☐ yes When? _____

Aer you currently on any medications? _____

Allergies? ☐ no ☐ yes Which one? _____

Are you taking any anticoagulant medicine? ☐ no ☐ yes Which one? _____

Have you responded to the state program SVIT? Bring your letter with you ! ☐ no ☐ yes

How many times you gave birth? _____

Were there any special features during child birth (episiotomy, injury, fast delivery, instrumental delivery...)? _____

Your signature: _____

Name and surname: _____

Date of birth: _____

Address: _____

Consent for ambulatory examination - procedure

Your phone number: _____

Allow presence on examination and or procedure any other medical (co)workers and medicine students for their learning ☐ no ☐ yes

Allow to pass on my healthcare information ☐ no ☐ yes To whom? _____

Allow to pass on to my e-mail my medical report and any other vital medical information ☐ no ☐ yes

Your e-mail address: _____

The physician's explanatory duty regarding planned interventions:
I am aware that, when examined, doctor evaluate my condition and considering all medicines and other therapies, perform a medical procedure in order to treat my illness and prevent further health consequences and disorders that could occur due to non-implementation of procedure or examination.

Planned procedures are:

- **Rectoskopy**
- **Proctoskopy**
- **Rubber ligature setting**

I am familiar with the fact that after the oral explanation of the doctor:

- Ask additional questions
- I am familiar with the consequences of not treating my illness,
- I am consenting to the planned procedure,
- Cancell my consent
- I cancel my consent during my treatment.

By **signing**, I confirm the understanding of the above instructions and give my own **consent**:

Patient or guardian signature:	Place and date:	Doctors signature:
_____	_____	_____

By signing, you also **consent** to the processing of your health and other personal data for purposes outside medical care:

Patient or guardian signature:	Place:	Date:
_____	_____	_____

With this signature I **cancel** the consent given above:

Patient or guardian signature:	Place:	Date:
_____	_____	_____