Subjective Data: Allergies: _______________________
Chief complaint: ___________________________________________________________________________________
Onset: ______________ q New Onset  q Chronic

History:

| Last bowel movement: ___________________________ | Color/Consistency: ___________________________ |
| History of dietary habits: ___________________________ |
| History of fluid intake/restriction: ___________________________ |
| History of laxative use: q Yes  q No  Comments: ___________________________ |
| History of hemorrhoids: q Yes  q No  Comments: ___________________________ |
| History of anal sex: q Yes  q No  Comments: ___________________________ |
| History of bleeding: q Yes  q No  Comments: ___________________________ |
| Pain: q Yes  q No  Pain scale: (0-10) __________ |

Associated Symptoms:

- Bleeding
- Constipation
- Diarrhea
- Small amount
- Moderate amount
- Large amount
- Burning
- Straining with stool

Objective Data: (clinically indicated VS)

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>Resp.</th>
<th>Temp.</th>
<th>Wt.</th>
<th>O2 sats.</th>
<th>FSBS:</th>
</tr>
</thead>
</table>

Rectal area:

- External protrusion
- Torn skin tissue
- Ulcers
- No external protrusions
- Bleeding around anal area
- Purulent discharge
- Inflammation
- Edema

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: Health care provider must be called if not on site or if after clinic hours.

- Significant rectal bleeding

REFER TO HEALTH CARE PROVIDER IF: If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.

- Anal warts or fissure
- No improvement after one week
- Patient is HIV positive
- Suspected syphilis, gonorrhea or herpes

Health Care Provider: ________________ Time Notified: ________ Orders Received for Treatment: q Yes  q No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

- Check in assessment only for health care providers visit.
- Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
- Hemorrhoidal suppositories rectally 3 times a day for 4 days PRN, especially in the morning and at night after bowel movement.

OR

- Hemorrhoidal ointment 3 times a day for 4 days PRN, especially in the morning and at night after bowel movement.
- Psyllium (i.e. Fiber Tabs) 2 tablets each evening for 30 days PRN with 8 oz of water.
- Hydrocortisone cream 1% 2 times a day for 10 days PRN, especially in the morning and at night after bowel movement for symptomatic relief of itching to affected area.
- Education/Intervention: Instructed to exercise, increase water intake to 8 glasses daily/fibrous foods, avoid straining when passing stool, limit prolonged sitting or standing, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____________________________________________________________

Health Care Provider Signature/Credentials: ___________________________ Date: ________ Time: ________

RN/LPN Signature/credentials: ___________________________ Date: ________ Time: ________

Name (Last, First)  DOC #