

Hernia History Form

Patient Name: _____

Today's Date: _____

What is the reason for today's visit?

☐ Groin hernia (inguinal or femoral) ☐ Right ☐ Left ☐ Both

☐ Ventral or Incisional hernia

☐ Umbilical hernia (belly button)

☐ Other (please specify) _____

What symptoms do you experience (check all that apply)?

☐ Any bulges or swelling in your groin, abdomen or genitals?

If yes, can you reduce the bulge by pressing it in? ☐ Yes ☐ No

☐ Any pain throughout the day or when standing for long periods of time?

☐ Any pain with lifting, coughing or sneezing?

☐ Any aching or throbbing in your genitals?

☐ Any pain with bowel movements or urination?

☐ I do not have any symptoms

Have you had any previous surgeries for this problem? ☐ Yes ☐ No

If yes, please specify _____

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, please specify _____

Have you had any X-rays taken regarding your visit today? ☐ Yes ☐ No

If yes, please specify when and where? _____