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? _____