

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 in it? 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? _____