BEVERLY HILLS hernia center

450 North Roxbury Drive, #224 • Beverly Hills, California 90210
TEL 310.358.5020 FAX 310.358.5025
beverlyhillsherniacenter.com

HERNIA HEALTH QUESTIONNAIRE

(Please Print Clearly)

General Information

Last Name: **Today's Date:** __ __ / __ __ / __ __

First Name: **Marital Status:** ❑Single ❑Married ❑Divorced ❑Widowed ❑Other: _____

Birth Date: __ __ / __ __ / __ __ **Age:**___ **Gender:** ❑Male ❑Female

Current or Most Recent Occupation: _____

Employment Status: ❑Full Time ❑Part Time ❑Unemployed ❑Retired ❑Other: _____

Daily Activities: Heavy Lifting ❑Yes ❑No | Routine Exercise ❑Yes ❑No

Race/Ethnicity: *(Check all that apply)*

❑Asian ❑Pacific Islander/ Hawaiian
❑Black
❑Hispanic ❑Native American
❑White ❑Unknown
❑Filipino ❑Other: _____

Medical History

Height: ____ft____in **Weight:** _____lbs **Smoking tobacco:** ❑Yes ❑No ❑Quit _____

If yes: How many packs per day? _____ How many years? _____

Personal History: *(Check all that apply)*

❑Ascites
❑Asthma/Bronchitis
❑Chronic cough
❑Clearing of throat
❑Constipation (push to have a bowel movement)
❑COPD
❑Diabetes
❑Healing disorder
❑Overweight or obese
❑Acid reflux/GERD
❑Sleep apnea
❑Strain to urinate (enlarged prostate, prolapsed bladder)

Pregnancy History (for females only)
Number of Deliveries: _____
Mode of Delivery: *(Check all that apply)* ❑Vaginal ❑Cesarean Section

Medications: *(Check all that apply)*

❑Steroids (Hydrocortisone, Prednisone) ❑Immune suppression

❑Pain control Please specify:

Hernia Details

Previous Hernia: ❑Yes ❑No
If yes: Location/Type: _____
Treatment: _____

Anyone with hernias in your family? ❑Yes ❑No
Relationship: _____

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Pain and Discomfort

(Please Print Clearly)

Pain

Are you experiencing any **Pain** from your hernia? ❑Yes ❑No

Type of Pain: *(Check all that apply)* ❑Burning ❑Dull ❑Pinching ❑Sharp ❑Shooting ❑Other: _____	**Location of Pain:** *(Check all that apply)* ❑Abdomen ❑Back ❑Groin ❑Leg ❑Scrotum/Labia ❑ Other: _____
How long have you been experiencing this pain? *(number of weeks)* _____(weeks)	**Frequency:** ❑Daily ❑Weekly ❑Monthly ❑Occasionally/Rarely

Pain Scale: (Least) 1 – 10 (Most)
Lowest Pain Level:____ Highest Pain Level:____ Current Pain Level:____

Discomfort

Are you experiencing any **Discomfort** from your hernia? ❑Yes ❑No

When do you experience discomfort? *(Check all that apply)*

- ❑Prolonged standing
- ❑Prolonged sitting
- ❑Coughing, Laughing
- ❑Sneezing
- ❑Sexual intercourse
- ❑Straining (when urinating or having a bowel movement)
- ❑Pain lingers after straining
- ❑Walking up/down stairs
- ❑Getting out of a car or out of bed
- ❑Bending, such as tying shoelaces
- ❑Crossing legs
- ❑Best when lying flat
- ❑Worse at end of day
- ❑Worse during periods (for women only)
- ❑Other: _____

How long have you been experiencing this discomfort? *(number of weeks)* _____(weeks)

Comments, Concerns, and Feedback

Any additional information you think that your doctor should know.

What did you think about this form? Please offer us any feedback on how we can improve it.

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General Information

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How were you referred to see Dr. Towfigh?	Name of your General Physician:
❑Internet ❑My insurance ❑Physician: _____ ❑Previous Patient ❑Other: _____	

Medications *Please list all the medications that you are currently taking.*

Allergies *Please list all your known allergies and their reactions.*

Medical History *List all your known medical conditions.*

Surgical History *Please list any operations or hospitalizations.*

Thank you!