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:**___	**Sex:** ❑Male ❑Female	**Race/Ethnicity:** *(Check all that apply)* ❑Asian ❑Black ❑Hispanic ❑White ❑Filipino ❑Pacific Islander/ Hawaiian ❑Native American ❑Unknown ❑Other: _____
Current or Most Recent Occupation: _____			
Employment Status: ❑Full Time ❑Part Time ❑Unemployed ❑Retired ❑Other: _____			
Daily Activities:	Heavy Lifting ❑Yes ❑No	Routine Exercise ❑Yes ❑No	

Medical History

Height: ____ft____in	**Weight:** _____lbs	**Any Nicotine Use:** ❑Yes ❑No ❑Quit _____	**Do you smoke Marijuana?** ☐ Yes ☐ No

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 including the dosage.*

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!