VAIL HEALTH

HERNIA PATIENT HEALTH HISTORY

GENERAL INFORMATION

Last Name		**First Name**	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
DOB	**Age**	**Gender** ◯ M ◯ F	**Race/Ethnicity**
Occupation/Most Recent Occupation			
Employment Status	☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Other		
Daily Activities	Heavy lifting? ◯ Yes ◯ No	Routine exercise? ◯ Yes ◯ No	
How were you referred to Vail Health?			
Primary Care Physician	Name	Phone Number	
Preferred Pharmacy	Name	Phone Number	
Local Resident?	◯ Yes ◯ No ◯ Part Time		

MEDICAL HISTORY

Height	feet	inches	**Weight**	pounds		
Smoking	◯ Yes ◯ No	☐ Tobacco	☐ Vaporizer	☐ PPD	Years	Date Quit
Medications						
Specific medications	☐ Steroids	☐ Immuno-suppression	☐ Pain medications			
Allergies						

Any of the following:

☐ Asthma ☐ Bronchitis/COPD ☐ Chronic cough ☐ Constipation ☐ Diabetes
☐ Problems with healing, scarring, bruising ☐ Obesity (BMI >30) ☐ GERD/Reflux ☐ OSA ☐ BPH

Medical History		
Surgical History		
Family History		
Pregnancy History	Number of deliveries	Modes of delivery ☐ Cesarean ☐ Vaginal

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HERNIA DETAILS

Previous Hernia? ◯ Yes ◯ No	Type	Treatment	
Family History of Hernias? ◯ Yes ◯ No	Type	Treatment	

Hernia Symptoms (check all that apply)

Pain ◯ Yes ◯ No

Type

- ☐ Burning
- ☐ Dull
- ☐ Stabbing
- ☐ Pinching
- ☐ Sharp
- ☐ Referred
- ☐ Other

Location

- ☐ Groin
- ☐ Back
- ☐ Scrotum/Labia
- ☐ Abdomen
- ☐ Legs
- ☐ Other

Length of time ☐ Weeks ☐ Months ☐ Years

Frequency ☐ Rarely ☐ Occasionally ☐ Daily ☐ Weekly ☐ Monthly

Pain scale (1-10) Lowest ever Highest ever Current

Discomfort ◯ Yes ◯ No

When

- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Coughing/sneezing
- ☐ Laughing
- ☐ Worse at the end of the day
- ☐ Other
- ☐ Worse during menses (women only)
- ☐ Getting out of (bed, chair, car)
- ☐ Intercourse
- ☐ Bending
- ☐ Twisting
- ☐ Crossing legs
- ☐ Lying down
- ☐ Stairs (up/down)
- ☐ Straining (BM/urination)

How long ☐ Weeks ☐ Months ☐ Years