

HERNIA CENTER HEALTH HISTORY QUESTIONNAIRE

Please complete this questionnaire in full. This information will assist us in your care plan. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

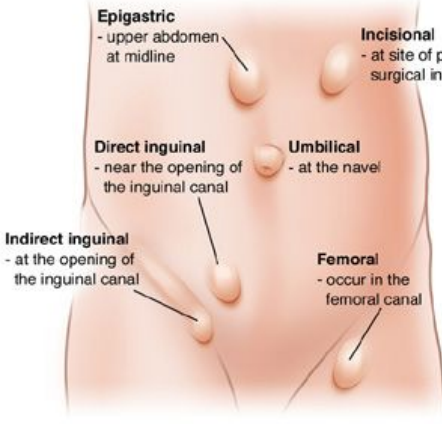
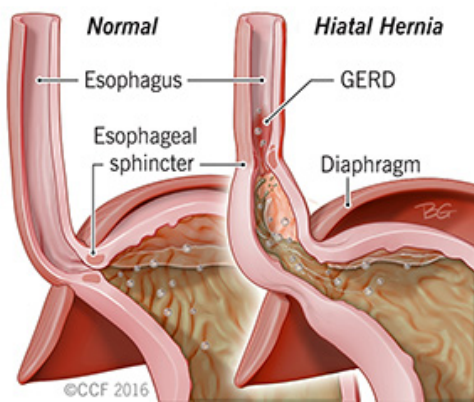
For patients living at a distance, this questionnaire is designed to help facilitate your examination, admission, and surgery in one visit. However, an in-person physical examination at our clinic is required to make a final diagnosis and a treatment plan.

Please fax a completed copy to 631-638-0050.

Name <i>(Last, First, M.I.):</i>	
DOB:	
<input type="checkbox"/> M <input type="checkbox"/> F	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Race: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> Other _____	
Address:	City, State, Zip:
Home Phone:	Cell/Work Phone:
Email:	Language:
Referring doctor:	Date of last physical exam:
Emergency Contact:	Emergency Contact Phone:
Occupation/Retired:	Employer:
Business Address:	Business Phone Number:
How did you hear about us? <input type="checkbox"/> Medical Doctor: _____ <input type="checkbox"/> Friend <input type="checkbox"/> Article <input type="checkbox"/> Website: _____ <input type="checkbox"/> Other: _____	
Surgeon Requested:	
<input type="checkbox"/> Andrew Bates	<input type="checkbox"/> Salvatore Docimo
<input type="checkbox"/> Kathreen Lee	<input type="checkbox"/> Michael Paccione
<input type="checkbox"/> Daniel Rutigliano	<input type="checkbox"/> Samer Sbayi
<input type="checkbox"/> Konstantinos Spaniolas	<input type="checkbox"/> James Vosswinkel
<input type="checkbox"/> Polikseni Eksarko	<input type="checkbox"/> Jill Genua
<input type="checkbox"/> Aurora Pryor	<input type="checkbox"/> Jerry Rubano
<input type="checkbox"/> Jessica Schnur	<input type="checkbox"/> Marc Shapiro

HEALTH INSURANCE INFORMATION		
Insurance Carrier:		Insurance ID:
Primary Insured:	DOB:	Primary Insured Relationship:
Secondary Insurance Carrier:		Secondary Insurance ID:
Primary Insured:	DOB:	Primary Insured Relationship:

PERSONAL HEALTH HISTORY

Height:	Weight	BMI	Recent Weight Gain or Loss:
Waist at the navel (inches):			Chest, not expanded (inches):
Have you had hernia surgery before: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which type?			
Have you had a medical evaluation of your suspected hernia confirming a hernia present: <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia Type:			
Are you inquiring about a Shouldice repair for your inguinal, umbilical, ventral or incisional hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hernias that you want repaired:			
			
		PLEASE CHECK: <input type="checkbox"/> Epigastric Hernia <input type="checkbox"/> Femoral Hernia <input type="checkbox"/> Incisional Hernia <input type="checkbox"/> Inguinal Hernia: Right or Left <input type="checkbox"/> Paraesophageal/Hiatal Hernia <input type="checkbox"/> Spigelian Hernia <input type="checkbox"/> Umbilical Hernia <input type="checkbox"/> Ventral Hernia	
RIGHT Inguinal or Femoral		LEFT Inguinal or Femoral:	
Is this your first RIGHT groin hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this your first LEFT groin hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous repairs? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last repair:		Previous repairs? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last repair:	
Can you reduce (push back in) your hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can you reduce (push back in) your hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Size of hernia: <input type="checkbox"/> No Noticeable bulge <input type="checkbox"/> Walnut <input type="checkbox"/> Egg <input type="checkbox"/> Grapefruit		Size of hernia: <input type="checkbox"/> No Noticeable bulge <input type="checkbox"/> Walnut <input type="checkbox"/> Egg <input type="checkbox"/> Grapefruit	
Umbilical, Epigastric, Spigelian, or Ventral Hernia:		Para-esophageal, Hiatal, or Diaphragmatic Hernia:	
Is this your first hernia of this type? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this your first hernia of this type? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous repairs? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last repair:		Previous repairs? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last repair:	
Can you reduce (push back in) your hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No		Can you reduce (push back in) your hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Size of hernia: <input type="checkbox"/> No Noticeable bulge <input type="checkbox"/> Walnut <input type="checkbox"/> Egg <input type="checkbox"/> Grapefruit		Are you experiencing reflux: <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
For incisional hernia, what was the original operation?		Do you experience: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Aspiration <input type="checkbox"/> Chest Pain	
Additional Information About Your Hernia(s):			
Has the hernia(s) identified above been diagnosed by a medical doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, how? <input type="checkbox"/> Physical Exam <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other:			
Are you experiencing chronic pain from a previous hernia repair? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you experienced a wound infection in any previous surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you have mesh placed during a previous hernia surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of the Drug	Strength	Frequency Taken
Do you take buprenorphine ,suboxone ,naltrexone or similar?		

Allergies to medications	
Name the Drug	Reaction You Had

Have you ever had, past or present?	Yes / No / Other	Details to all questions answered yes
Abnormal reaction to local or general anesthetic or history of malignant hyperthermia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A family member that has had an abnormal reaction to anesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Heart trouble, heart attack, angina, mechanical valves, or irregular heartbeat?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A history of blocked artery in the heart, heart failure, Ischemic heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A History of chest pain while performing activities, or while resting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	

Have you ever had, past or present?	Yes / No / Other	Details to all questions answered yes
Autoimmune disease (chronic inflammatory state)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Active hepatitis or a history of liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A history of peripheral arterial disease (poor blood flow to the legs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Abnormal blood pressure, high or low, or pulmonary hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Medicine for your heart or high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Difficulty with breathing or had unusual tiredness or weakness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Pacemaker or defibrillator implanted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have any other implanted devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Lung illness, asthma, emphysema, chronic bronchitis, or tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Severe snoring?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Sleep apnea or do you sleep with a breathing machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Difficult laryngoscopy or narrowing of windpipe?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Difficult intubation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Medicine for asthma or other lung illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Lightheaded when you get up, even when not standing abruptly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Scoliosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Kidney illness or problems with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Frequent urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
History of end stage renal disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	

Does any family member have easy bruising or unusual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Severe or unusual bleeding following any trauma, cut or dental extraction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A blood disorder (high or low platelets, hemoglobin or white cells)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Blood clots in the legs, (DVT) or in the lungs (pulmonary embolism)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Diabetes or abnormal blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Frequent urination, blurred vision, and strong thirst?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Problems with digestion, bowel function, bleeding or vomiting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Jaundice, hepatitis, cirrhosis, or ascites (fluid in the abdomen)? When? Type?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A sexually transmitted disease or been exposed to/tested positive for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Steroids, prednisone, cortisone, ACTH or related medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
A stroke, unusual dizziness, blackouts, tremors, or memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have any neurological disorders (e.g. Parkinson's, Epilepsy, Dementia)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have any neuromuscular disorders (e.g. Myasthenia gravis, multiple sclerosis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have any arthritis, lupus or rheumatological disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have any loose teeth, capped teeth, or false teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have problems with eyesight or wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you smoke or use tobacco or electronic cigarettes? How much per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you cough or have sputum from smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you use street or recreational drugs or are you on a drug maintenance program?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you drink alcohol? How often and how many drinks per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have cultural or religious practices or requirements that we should know of?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you have any special needs or require supervision or attendant care (e.g. Vision, mobility, dietary, disability)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	

Do you live alone, in a retirement home or nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Are you allergic to anything (e.g. medication, food, environmental, latex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Were you hospitalized in the past 6 months for anything?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Are you pregnant or within 12 months of the end of a pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Have you undergone chemotherapy in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Have you undergone radiation therapy near your hernia in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Have you ever had cancer, chemotherapy or radiation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Can you climb two flights of stairs without shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Have you ever been diagnosed with MRSA?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Do you take herbal medications? If so, which ones?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Have difficulty taking care of yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
Have difficulty doing housework like vacuuming, or moderate recreational activities like golf or dancing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other	
How do you rate your health right now?	Good Fair Poor	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		

	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day _____ <input type="checkbox"/> Chew - #/day _____ <input type="checkbox"/> Pipe - #/day _____	<input type="checkbox"/> Cigars - #/day _____	
	<input type="checkbox"/> # of years _____ <input type="checkbox"/> Or year quit _____		
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

Family Member	AGE	SIGNIFICANT HEALTH PROBLEMS	Family Member	AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			<input type="checkbox"/> M	
	<input type="checkbox"/> M			<input type="checkbox"/> F	
	<input type="checkbox"/> F			Grandmother	
	<input type="checkbox"/> M			<i>Maternal</i>	
	<input type="checkbox"/> F			Grandfather	
<input type="checkbox"/> M			<i>Maternal</i>		
<input type="checkbox"/> F			Grandmother		
<input type="checkbox"/> M			<i>Paternal</i>		
<input type="checkbox"/> F			Grandfather		
			<i>Paternal</i>		

MENTAL HEALTH

Do you suffer from depression, anxiety schizophrenia, ADHD, OCD or any other psychiatric condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation: _____		
Date of last menstruation: _____		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies: _____	Number of live births: _____	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam? _____		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Please list any doctors you see:

Name _____	Specialty _____	Phone Number _____
Name _____	Specialty _____	Phone Number _____
Name _____	Specialty _____	Phone Number _____
Name _____	Specialty _____	Phone Number _____

The Shouldice repair has demonstrated continued success for over 70 years as practiced at Shouldice Hospital in Canada, ***if the patient has acceptable weight for their height.*** Weight is a very important factor. If the patient's body frame is large, we can relax on the increased weight, but if it is small, then weight becomes a problem.

Small body frame in and of itself isn't an issue for the repair, but is looked at when examining a patient's weight. Hence, small body frame and not overweight is encouraging, but small body frame and overweight needs to have weight loss. Large body frame better distributes the body weight because of the larger frame, but weight is still strongly considered during the discussion.

Overweight poses a potential risk for recurrence, bleeding, infection, and chronic pain. The following table used at Shouldice Hospital (founded by Dr. Shouldice) shows ideal weights for height and [body frame size](#):

Men's Body Frame Size				Women's Body Frame Size			
Height	Small	Medium	Large	Height	Small	Medium	Large
5'6"	158 lb	167 lb	182 lb	4'10"	125 lb	136 lb	147 lb
5'7"	161 lb	170 lb	186 lb	4'11"	128 lb	139 lb	150 lb
5'8"	164 lb	173 lb	190 lb	5'0"	131 lb	142 lb	153 lb
5'9"	167 lb	176 lb	194 lb	5'1"	134 lb	145 lb	157 lb
5'10"	170 lb	180 lb	198 lb	5'2"	137 lb	148 lb	161 lb
5'11"	174 lb	184 lb	202 lb	5'3"	140 lb	151 lb	165 lb
6'0"	178 lb	188 lb	207 lb	5'4"	143 lb	154 lb	169 lb
6'1"	182 lb	192 lb	212 lb	5'5"	146 lb	157 lb	173 lb
6'2"	186 lb	197 lb	217 lb	5'6"	149 lb	160 lb	177 lb
6'3"	190 lb	201 lb	221 lb	5'7"	152 lb	163 lb	180 lb
6'4"	194 lb	205 lb	225 lb	5'8"	155 lb	166 lb	183 lb
6'5"	198 lb	209 lb	229 lb	5'9"	158 lb	169 lb	186 lb
6'6"	204 lb	221 lb	233 lb	5'10"	161 lb	172 lb	189 lb

Verification of information:

By signing below, you acknowledge that the information given in this packet is accurate to the best of your knowledge.

 CLIENT'S NAME (Please print)

 SIGNATURE OF CLIENT OR SIGNATURE OF GUARDIAN TO CLIENT

 DATE

PERMISSION TO EXCHANGE INFORMATION:

I, _____ HEREBY GRANT PERMISSION FOR COMMUNICATION BETWEEN THE PROFESSIONAL STAFF OF The STONY BROOK MEDICINE HERNIA CENTER, REGARDING ANY AND ALL OF MY PSYCHOLOGICAL, MEDICAL, PSYCHIATRIC, RADIOLOGICAL, EDUCATIONAL AND SOCIAL RECORDS AS RELATED TO MY ENGAGEMENT IN THE HERNIA CENTER'S PROGRAMS AND/OR HERNIA SURGERY INTERVENTIONS.

 CLIENT'S NAME (Please print)

 SIGNATURE OF CLIENT OR SIGNATURE OF GUARDIAN TO CLIENT

 DATE

In addition, I also grant permission for exchange of information with:

 (Indicate name; include address and phone if possible)