HERNIA CENTER OF OHIO
MEDICAL QUESTIONNAIRE/ REGISTRATION

All information is kept strictly confidential. Please click SUBMIT when finished. For online questionnaires, Dr. Grischkan will call you after reviewing your medical information. The phone call will identify an UNLISTED number. If you have any questions please call our clinic at 216-591-1422.

DATE_____ NAME_____

SEX : ____M ____F ____N.A. DATE OF BIRTH_____ AGE_____

HEIGHT_____ WEIGHT_____ lbs

OCCUPATION _____ EMPLOYER _____

	ADDRESS	UNIT #	CITY	STATE	ZIP
HOME:	_____	_____	_____	_____	_____
BUSINESS:	_____	_____	_____	_____	_____

COUNTRY: _____

TELEPHONE

HOME	OFFICE	CELL	EMAIL
_____	_____	_____	_____

EMERGENCY CONTACT: NAME _____ TEL _____

REFERRED BY: ☐ PHYSICIAN ☐ NON PHYSICIAN

Doctor's Name _____ Patient _____

Address _____ Family/Friend _____

City _____ Newspaper _____

State _____ Zip _____ Internet _____

Telephone _____ Other _____

INSURANCE (check one): ☐ Have Insurance ☐ Do Not Have ☐ Organization Sharing

INSURANCE COMPANY _____ TEL _____

CARDHOLDER NAME _____

GROUP NUMBER _____ ID# _____

WORKER'S COMPENSATION CLAIM: ☐ Yes ☐ No

Date of Injury _____ How Injured _____

NAME _____ DOB _____

MEDICAL HISTORY

Do YOU have any history of the following disorders? If yes, place an x in the box that applies.

HEAD AND NECK DISORDERS: ☐ No ☐ Yes

- ☐ glaucoma
- ☐ stroke
- ☐ seizures
- ☐ anxiety
- ☐ depression
- ☐ mental illness
- ☐ Alzheimer's/dementia
- ☐ other_____

HEART CONDITION: ☐ No ☐ Yes

- ☐ irregular heart beat
- ☐ heart attack year_____
- ☐ chest pain recently
- ☐ high blood pressure
- ☐ congestive heart failure
- ☐ pacemaker
- ☐ mitral valve prolapse
- ☐ blood clots
- ☐ other _____

LUNG DISORDER: ☐ No ☐ Yes

- ☐ asthma
- ☐ COPD (emphysema)
- ☐ chronic cough
- ☐ pulmonary embolus
- ☐ shortness of breath
- ☐ other _____

GASTROINTESTINAL DISORDERS: ☐ No ☐ Yes

- ☐ acid reflux (GERD)
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ hepatitis
- ☐ cirrhosis
- ☐ rectal bleeding (black stool)
- ☐ chronic constipation
- ☐ hiatal hernia
- ☐ ulcers
- ☐ other _____

URINARY DISORDERS: ☐ No ☐ Yes

- ☐ frequent urinary tract infections
- ☐ kidney stones
- ☐ kidney failure
- ☐ frequent nighttime urination
- ☐ bloody urine
- ☐ difficulty urinating
- ☐ other _____

ENDOCRINE DISORDERS: ☐ No ☐ Yes

- ☐ diabetes
- ☐ thyroid condition type _____
- ☐ adrenal disorder
- ☐ autoimmune disorder type _____

HEMATOLOGIC DISORDERS: ☐ No ☐ Yes

- ☐ anemia
- ☐ leukemia
- ☐ clotting disorder
- ☐ hemophilia
- ☐ abnormal bleeding
- ☐ lymphoma
- ☐ other _____

TAKING BLOOD THINNERS: ☐ No ☐ Yes Name _____ Dose _____

NAME _____ DOB _____

ORTHOPEDIC CONDITIONS: ☐ No ☐ Yes

☐ arthritis
☐ metal implants
☐ other _____

GYNECOLOGIC: ☐ number pregnancies _____

☐ number deliveries _____

☐ history cancer Type _____

NEUROLOGIC CONDITIONS: ☐ No ☐ Yes Type _____

GENERAL/LIFESTYLE: ☐ cigarette smoker ☐ No ☐ Yes ____pk/day ____years

☐ alcohol in excess ☐ No ☐ Yes

☐ history cancer ☐ No ☐ Yes type _____

CHRONIC MEDICAL CONDITIONS/PROBLEMS: ☐ No ☐ Yes

Type _____

ALLERGIES TO MEDICATIONS: ☐ No ☐Yes

☐ If yes which one(s) _____

_____

_____

_____

_____

LATEX ALLERGY ☐ No ☐ Yes

CURRENT MEDICATIONS: ☐ None ☐ Yes

NAME	DOSAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NAME _____ DOB _____

HERNIA INFORMATION

LOCATION(S)-place X where hernia is DURATION-how many weeks/months/years has hernia been present

SIZE-marble, golfball, orange, huge PAIN 0=none 10=excrutiating

TYPE PAIN-burning/ stabbing/ cramping/ pressure (use more than one if needed)

	LOCATION	DURATION	SIZE	PAIN(0-10)	TYPE PAIN
Right groin	_____	_____	_____	_____	_____
Left groin	_____	_____	_____	_____	_____
Upper abdomen (midline)	_____	_____	_____	_____	_____
Lower abdomen (midline)	_____	_____	_____	_____	_____
Bellybutton	_____	_____	_____	_____	_____
Other (side/flank)	_____	_____	_____	_____	_____

LIMITATIONS CAUSED BY PAIN/HERNIA: ☐ No Limitations ☐ Yes (have limitations)

If Yes describe(example- exercise, sex, lifting, standing, etc)_____

FAMILY HISTORY OF HERNIAS: ☐ No ☐ Yes (if yes place x for family member)

☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Child

PREVIOUS HERNIA SURGERY: ☐ None ☐ Yes

TYPE PROCEDURE(inguinal, umbilical, etc)	LOCATION(right, left, midline, etc)	MONTH/YEAR
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS NON HERNIA SURGERY: ☐ None ☐ Yes

TYPE PROCEDURE	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____