HERNIA CENTER OF OHIO MEDICAL QUESTIONNAIRE / REGISTRATION

Date: _____

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.

Name: _____ **Date of Birth:** _____

Sex: ◯ Male ◯ Female **Age:** _____

Height (feet & inches): _____ **Weight (lbs):** _____

Email: _____ **Cell Phone:** _____

Home Address: _____ **Home Phone:** _____

_____ _____ _____ _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Employer: _____ **Occupation:** _____

Employer's Address: _____ **Office Phone:** _____

_____ _____ _____ _____

Referred by: ◯ Physician ◯ Non-Physician

Physician's Name: _____ **Physician's Phone:** _____

Physician's Address: _____

_____ _____ _____ _____

Non-Physician Referrer's Name:

Non-Physician Referrer Type: ◯ Patient ◯ Family Friend ◯ Newspaper ◯ Internet ◯ Other

Insurance: ◯ No ◯ Yes ◯ Organization Sharing

Cardholder's Full Name: _____

Insurance Company Name: _____ **Insurance Company Phone:** _____

Group Number: _____ **ID Number:** _____

Worker's Compensation Claim? ◯ No ◯ Yes **Date of Injury:** _____

How did you get injured?

MEDICAL HISTORY

For each section, please select any of the following disorders that you suffer from. Select none, if the section does not apply to you.

Head and Neck Disorders

- [ ] none
- [ ] glaucoma
- [ ] stroke
- [ ] seizures
- [ ] anxiety
- [ ] depression
- [ ] mental illness
- [ ] Alzheimer's / dementia
- [ ] Other

Head and Neck Disorders-Other, please explain

Heart Conditions

- [ ] none
- [ ] irregular heart beat
- [ ] heart attack
- [ ] chest pain recently
- [ ] high blood pressure
- [ ] congestive heart failure
- [ ] pacemaker
- [ ] mitral valve prolapse
- [ ] blood clots
- [ ] other

Heart Attack Year _____

Heart Conditions-Other, please explain

Lung Disorders

- [ ] none
- [ ] asthma
- [ ] COPD (emphysema)
- [ ] chronic cough
- [ ] pulmonary embolus
- [ ] shortness of breath
- [ ] other

Lung Disorders-Other, please specify

Gastrointestinal Disorders

- [ ] none
- [ ] acid reflux (GERD)
- [ ] Crohn's disease
- [ ] ulcerative colitis
- [ ] hepatitis
- [ ] cirrhosis
- [ ] rectal bleeding (black stool)
- [ ] chronic constipation
- [ ] hiatal hernia
- [ ] ulcers
- [ ] other

Gastrointestinal Disorders-Other, please specify

Urinary Disorders

- [ ] none
- [ ] frequent urinary tract infections
- [ ] kidney stones
- [ ] kidney failure
- [ ] frequent nighttime urination
- [ ] bloody urine
- [ ] difficulty urinating
- [ ] other

Urinary Disorders-Other, please specify

Endocrine Disorders

- [ ] none
- [ ] diabetes
- [ ] thyroid condition
- [ ] adrenal disorder
- [ ] autoimmune disorder

Diabetes Type _____ **Thyroid Condition Type** _____ **Autoimmune Disorder Type** _____

Hematologic Disorders

- [ ] none
- [ ] anemia
- [ ] leukemia
- [ ] clotting disorder
- [ ] hemophilia
- [ ] abnormal bleeding
- [ ] lymphoma
- [ ] other

Hematologic Disorders-Other, please specify _____

Taking Blood Thinners ◯ No ◯ Yes **Blood Thinner Name** _____ **Blood Thinner Dose** _____

MEDICAL HISTORY (CONTINUED)

For each section, please select any of the following disorders that you suffer from. Select no, if the section does not apply to you.

Orthopedic Conditions ◯ No ◯ Yes

If yes, which orthopedic conditions?

☐ arthritis ☐ metal implants ☐ other

Orthopedic Conditions-Other, please specify _____

Gynecologic ◯ No ◯ Yes

Number of Pregnancies _____

Neurologic Conditions ◯ No ◯ Yes

Type(s) of Neurologic Condition(s) _____

Cigarette Smoker ◯ No ◯ Yes

How often do you smoke (i.e. packs a day)? _____

How many years have you smoked? _____

Alcohol in Excess ◯ No ◯ Yes

How many alcoholic drinks do you have per week? _____

Recreational Drugs ◯ No ◯ Yes

Types of Recreational Drugs that you take _____

History of Cancer ◯ No ◯ Yes

Type(s) of Cancer _____

Steroid Use (12 months) ◯ No ◯ Yes

Names of steroids that you take _____

Sleep Apnea ◯ No ◯ Yes

Illness in the Past 30 Days? ◯ No ◯ Yes

If yes, please describe the illness _____

Chronic ◯ No ◯ Yes

If yes, please describe the chronic condition _____

Any Medical Problems/Serious Illness? ◯ No ◯ Yes

If yes, please describe the medical problem _____

Do you or a close relative have a problem with anesthesia or muscle disease? ◯ No ◯ Yes

If yes, please describe the close relatives disease _____

Allergies to Medications ◯ No ◯ Yes

If yes, which medicines are you allergic to? _____

Latex Allergy ◯ No ◯ Yes

Current Medications ◯ None ◯ Yes

Medications:

Name	Dose

HERNIA INFORMATION & HISTORY

Please describe the hernia(s) you are experiencing. Select none, if the section does not apply to you.
Hernia Information Duration - How many months or years has hernia been present?
Size - marble | golfball | orange | huge
Pain - 0=none, 10=excrutiating
Pain Type - Burning | Stabbing | Cramping | Pressure (use more than one if needed)

Location	Duration	Size	Pain	Pain Type
Right Groin				
Left Groin				
Upper Abdomen (midline)				
Lower Abdomen (midline)				
Belly Button				
Other (side/flank, etc)				

Limitations Caused by Hernia Pain ◯ No ◯ Yes **If Yes, which limitations? Examples: Exercise, sex, lifting, standing, etc.**

Family History of Hernias ◯ None ◯ Yes

Family Members Affected

☐ Father ☐ Mother ☐ Brother

☐ Sister ☐ Child

Previous Hernia Surgery ◯ None ◯ Yes

List Hernia Type (inguinal, umbilical, etc.), Location (right, left, etc.) and Month/Year:

Hernia Type	Location	Month/Year

Previous Non-Hernia Surgery ◯ None ◉ Yes

List Type and Month/Year

Type	Month/Year

NOTES: