Monmouth Medical Center
Barnabas Health

Institute for Treatment of Complex Hernias
255 Third Avenue
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Patient Questionnaire

Please fill out the form below and bring it with you to your consult. Thank you !

Patient Information:

First name:_____ Last name: _____ Middle initial: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Business phone: _____ Cell phone: _____

Social security number: _____ D.O.B.: _____E Mail: _____

Marital status: M S W D Sex: M F Age: ____ Height: _____ Weight: _____

Employer: _____ Occupation: _____

Employer address: _____ City _____ State: _____ Zip code: _____

E-mail address: _____

Name of Primary Care Physician: _____

Phone number: _____ Fax number: _____

Spouse Information:

Spouse's name: _____ Business phone: _____

Who referred you to our office? _____

Primary physician's name: _____ Phone number: _____

Address: _____

Social History:

Do you smoke now? __yes __no

If yes, how much? _____

For how many years have/did you use tobacco? _____

If you have quit, how long ago? __yes __no

Do you consume alcohol now? __yes __no

If yes, how many times a week? _____

How many drinks each time? _____

For how many years do/did you drink alcohol? _____

If you have quit, how long ago? _____

If you are disabled, is it due to? __Physical ailments __Mental ailments

Do you have children? __yes __no

How many? _____

Medical History: **Do you have or have you ever had any of the following:**

Allergies to medications or foods: __yes __no

If yes, to which medications and what kind of reaction did you have:

_____

_____

Do you use recreational drugs? __yes __no

If yes, what do you use and how often?

_____

_____

Are you on blood thinners? __yes __no

If yes, why are you on it?

_____

Can you come off it? __yes __no

General:

__ Cancer
__ Fatigue
__ High lipids
__ HVI
__ High cholesterol
__ High triglycerides
__ Pancreatitis
__ Hepatitis B or C

If yes, since when and form of treatment (list medications prescribed):

_____

_____

Head and neck:

__ Blurred vision
__ Loss of vision
__ Double vision
__ Difficulty swallowing

If yes, since when and form of treatment (list medications prescribed):

_____

_____

Cardiovascular:

__ Chest pain
__ Heart attack
__ Stroke/ TIA
__ Pain in legs
__ Loss of pulses
__ Angina
__ Palpitations
__ Heart murmur
__ Cold feet
__ Low blood pressure

__ High blood pressure
__ Coronary bypass surgery
__ Thrombophlebitis
___ Cardiomyopathy
__ Atrial fibrillation
__ Congestive heart failure
__ Venous insufficiency
__ Other _____

If yes, since when and form of treatment (list medications prescribed):

_____

_____

Respiratory:

__ Shortness of breath
__ Wheezing
__ Sleep apnea
__ Snoring
__ Use of CPAP/BiPAP
__ Asthma
__ Emphysema
__ Sleep difficulties
__ Observed apnea spells
__ Awakening at night

If yes, since when and form of treatment (list medications prescribed):

_____

_____

Gastrointestinal:

__ Gastro-esophageal reflux
__ Bowel incontinence
__ Hepatitis
__ Gallbladder disease

If yes, since when and form of treatment (list medications prescribed):

_____

_____

Genitourinary:

__ Kidney stones/ kidney disease
__ Bladder incontinence
__ Dialysis
__ Leaking urine with coughing/ sneezing

If yes, since when and form of treatment (list medications prescribed):

_____

_____

Musculoskeletal:

__ Pain in joints
__ Knee pain
__ Leg swelling
__ Low back pain
__ Sciatica
__ Arthritis
__ Hip pain
__ Foot and/or ankle pain
__ Foot swelling
__ Herniated disc
__ Numbness in feet or legs
__ Muscle aches

If yes, since when and form of treatment (list medications prescribed)

_____

_____

Endocrine:

__ Hyperthyroid
__ Goiter
__ Juvenile diabetes
__ Oral medications for diabetes
__ Hypothyroid
__ Previous thyroid radiation
__ Adult onset diabetes
__ Insulin

If yes, since when and form of treatment (list medications prescribed)

_____

_____

Neurological:

__ Seizures
__ Muscle weakness
__ Fainting
__ Falling
__ Limb numbness
__ Light headness

If yes, since when and form of treatment (list medications prescribed)

_____

_____

Psychological:

__ Depression
__ Anxiety
__ Nervousness
__ Suicidal thoughts

If yes, since when and form of treatment (list medications prescribed)

_____

_____

Women:

__ Difficulty achieving pregnancy
__ Ovarian cysts
__ Irregular periods
__ Cessation of periods
__ Fibroids/ tumors in uterus
__ Painful periods
__ Heavy periods
__ Post menopausal

If yes, since when and form of treatment (list medications prescribed)

_____

_____

Surgical History:

Have you had any surgery? __yes __no

Did you have general anesthesia? __yes __no

If yes, did you have any problems? __yes __no

If yes, what kind of problems did you experience?

_____

If you have ANY previous surgery, please answer all of the following questions as thoroughly as you can

Date of surgery	Type of surgery	Complication, if any, from this surgery
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

17.		
18.		
19.		
20.		

Specific Hernia Information:

How did this hernia occur?

_____

_____

_____

What kind of problems does this hernia cause you?

_____

_____

_____

How does it affect your life style?

_____

_____

_____

Have you gone to the Emergency Room because of this hernia? __yes __no

Have you had to have any emergency surgery because of this hernia? __yes __no

If yes, please explain:

_____

_____

_____

Does this pain cause you:

___ chronic pain
___ inability to perform activities of daily living
___ nausea or vomiting
___ other _____

Family Medical History

__ Obesity
__ Stroke
__ High blood pressure
__ Heart disease
__ Diabetes
__ Other…

_____

_____

If any of the above are checked, please check the family members who have medical problems and specify the problem. If the family member is deceased, please specify the cause of death and age of death, if known:

Mother_____
_____

Father _____
_____

Maternal grandmother _____
_____

Paternal grandmother _____
_____

Maternal grandfather _____
_____

Paternal grandfather _____
_____

Brother/sister _____
_____

Children _____
_____

Children _____
_____

Children _____
_____

Other information you feel that we should know about:

_____

_____

_____

_____

_____

Patient signature: _____ Date: _____