

General Surgical Associates

HERNIA

Have you recently been troubled by any of the problems listed below? (Please Circle)

Weight gain

Chronic cough

Difficulty urinating (excessive straining)

Constipation

Nausea or Vomiting

Change in bowel movements

Does your work require frequent heavy lifting?

Yes

No

Are you having any of the following symptoms? (Circle Yes or No)

Fever

Yes

No

Easy fatigue

Yes

No

Chest pain or pressure

Yes

No

Heart palpitations

Yes

No

Blackouts

Yes

No

Shortness of breath

Yes

No

Wheezing or asthma attacks

Yes

No

Heartburn

Yes

No

Blood in stool or urine

Yes

No

Frequent or painful urination

Yes

No

Intense headaches

Yes

No

Seizures

Yes

No

9

Name: _____

DOB: _____

Signed: _____

Date: _____