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

Name:_____ DOB:_____

Signed:_____ Date:_____