MEDICAL INFORMATION QUESTIONNAIRE

Natural Tissue Hernia Repair Associates
20 York Mills Road North York, ON M2P 2C2
Telephone: 1 (877) 681-6002

For patients living at a distance, this Medical Questionnaire can help you arrange your examination, admission and operation all in one visit. However, it is only after the personal examination that a final diagnosis and treatment plan can be made.

The completion and return of this questionnaire will not put you under any obligation whatsoever.

Please be sure to answer ALL questions and all sections.

THIS FORM CAN BE COMPLETED ON YOUR COMPUTER AND SAVED, THEN SUBMITTED ON OUR WEBSITE AT www.naturaltissueherniarepair.com/form-submission.html

If you do not wish to email the the form, please fax the form to: (416) 250-5888.

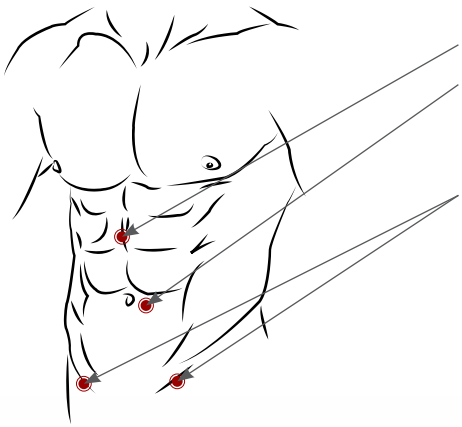
ALL QUESTIONS MUST BE ANSWERED ACCURATELY – please print clearly.
Incomplete or inaccurate answers may necessitate delay or cancellation of surgery. If in doubt, please consult your family physician.
All information will be treated as confidential. HIPAA COMPLIANT*

*Please visit http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/ for more information.

SECTION A

Family Name (Last Name):			
First Name/Initial:		Middle Name/Initial:	
Address:			
City:			
Province/State:		Postal Code/Zip:	
Home Phone (+00-000-000-0000):		Date of Birth (YYYY/MM/DD):	Gender: ☐ Male ☐ Female
Marital Status	Language	Religion	Advanced care directives (if any):
Next of Kin:		Telephone (+00-000-000-0000):	Skype username:
Are you a former patient of NTHRA? ☐ Yes ☐ No		If yes, what year (YYYY/MM)?	
Occupation	Self Employed? ☐ Yes ☐ No	Name of Employer	Bus Phone No (+00-000-000-0000):
Body Weight Information			
Height ft in	Weight: lbs kgs	Recent weight gain lbs kgs	Recent weight loss lbs kgs
Waist – relaxed (ins.)		What is your preferred admission date?	
How did you hear about NTHRA? ☐ Friend ☐ Article ☐ Internet ☐ Medical Doctor ☐ Other		If other, please explain:	

SECTION B



Mark with an "X" the position of each hernia you want repaired

EPIGASTRIC Hernias are above the navel. Place "x" here:

UMBILICAL Hernias are at the navel. Place "x" here:____

INGUINAL AND FEMORAL HERNIAS are in the groin area on either side. Place "x" here:

INCISIONAL Hernias bulge through the scar of any other type of surgical operation that has failed to hold. Place "x" here:

OTHER Hernias are through any other muscular weakness. Place "x" here:____

Please elaborate if you selected "other":

SECTION C DESCRIBE ONLY HERNIAS THAT YOU WANT REPAIRED

INGUINAL and FEMORAL HERNIAS

Right Groin

Is this your first RIGHT groin hernia? ☐ Yes ☐ No	If not, how many previous RIGHT repairs have there been?
If more than one, please elaborate.	
Date of last repair (YYYY/MM/DD):	Size of Hernia: ☐ Not Noticable ☐ Golf ball ☐ Pear (or more)

Left Groin

Is this your first LEFT groin hernia? ☐ Yes ☐ No	If not, how many previous LEFT repairs have there been?
If more than one, please elaborate.	
Date of last repair (YYYY/MM/DD):	Size of Hernia: ☐ Not Noticable ☐ Golf ball ☐ Pear (or more)

UMBILICAL, EPIGASTRIC HERNIAS

Is this your first UMBILICAL, EPIGASTRIC/OTHER hernia? ☐ Yes ☐ No	If not, how many previous repairs have there been?	
Was there a wound after last repair? ☐ Yes ☐ No	Date of last repair (YYYY/MM/DD):	Size of Hernia ☐ Nothing Noticable ☐ Golf ball ☐ Pear (or more)

INCISIONAL HERNIAS

Was the original operation for:

☐ Appendix ☐ Gall Bladder ☐ Stomach ☐ Caesarian ☐ Hysterectomy ☐ Hysterectomy ☐ Colon ☐ Other _____

If not, how many previous repairs have been attempted on this hernia?	Was there ever a wound infection? ☐ Yes ☐ No
Date of last repair (YYYY/MM/DD):	Size of Hernia: ☐ Not Noticable ☐ Golf ball ☐ Pear (or more)

SECTION D

List ALL medicines, pills and drugs that you have been taking during the past six months (including nerve and sleeping pills, anything with aspirin and other non-prescription medicines.

Name	Approximately how long have you been taking this?	Name	Approximately how long have you been taking this?

Other

SECTION E

HAVE YOU EVER HAD, PAST OR PRESENT.	
1. An abnormal reaction to a local or general anaesthetic?	☐ Yes ☐ No ☐ Don't Know
a. Has anyone in your family had an abnormal reaction?	☐ Yes ☐ No ☐ Don't Know
2. A heart attack, angina pain, irregularity or other illness or trouble with your heart?	☐ Yes ☐ No ☐ Don't Know
3. Abnormal blood pressure, high or low	☐ Yes ☐ No ☐ Don't Know
4. Do you take medicine or pills for your heart or high blood pressure? If " YES" please list BELOW	☐ Yes ☐ No ☐ Don't Know
5. Difficulty with breathing, unusual tiredness or weakness If " YES", please list BELOW	☐ Yes ☐ No ☐ Don't Know
6. Asthma, emphysema, chronic bronchitis, tuberculosis or other lung illness	☐ Yes ☐ No ☐ Don't Know
7. An allergic reaction to anything? If " YES", please list BELOW	☐ Yes ☐ No ☐ Don't Know
8. To take Prednisone, Cortisone, ACTH or related medicines? If " YES", please list BELOW	☐ Yes ☐ No ☐ Don't Know

SECTION E *(Cont'd)*

HAVE YOU EVER HAD, PAST OR PRESENT.	
9. Kidney illness or problems with urination?	☐ Yes ☐ No ☐ Don't Know
10. Diabetes or abnormal blood sugar?	☐ Yes ☐ No ☐ Don't Know
11. Problems with digestion, bowel function, unusual bleeding or vomiting?	☐ Yes ☐ No ☐ Don't Know
12. Jaundice or hepatitis? When?	☐ Yes ☐ No ☐ Don't Know
13. Sexually transmitted disease (V.D.)?	☐ Yes ☐ No ☐ Don't Know
14. Tested HIV positive?	☐ Yes ☐ No ☐ Don't Know
15. Stroke, unusual dizziness or blackouts?	☐ Yes ☐ No ☐ Don't Know
16. Severe or unusual bleeding following dental extractions or trauma?	☐ Yes ☐ No ☐ Don't Know
17. Do you have any loose, capped or false teeth? If "YES", please list BELOW	☐ Yes ☐ No ☐ Don't Know
18. Do you wear contact lenses?	☐ Yes ☐ No ☐ Don't Know
19. Do you smoke? How many per day? If " YES", please list BELOW	☐ Yes ☐ No ☐ Don't Know
20. How much alcohol do you drink per week? If " YES", please list in BELOW	☐ Yes ☐ No ☐ Don't Know
21. List below all types of surgery you have had in your life,with approximate dates	☐ Yes ☐ No ☐ Don't Know
22. Have you had other significant illnesses in your life? If "YES", please list BELOW with approximate dates	☐ Yes ☐ No ☐ Don't Know
21. Do you have other significant illnesses or medical problems NOW? If "YES", please list BELOW,with approximate dates	☐ Yes ☐ No ☐ Don't Know

SECTION F

NAME, ADDRESS & PHONE NUMBER OF PHYSICIAN TO CONTACT SHOULD ADDITIONAL MEDICAL INFORMATION BE REQUIRED		
Name:		
Address:		
City:	Province/State:	Postal / Zip Code:
Telephone (+00-000-000-0000):	Fax:	

☐ I consent to NTHRA and their associates to contact my health care providers on my behalf and may have free access to my medical information

Section G PATIENT ACKNOWLEDGEMENT

☐ By checking this box you acknowledge that the information given above is true.	
Patient Name:	Date (YYYY/MM/DD):
Credit Card Number	
Type of Card (Credit Card information is required to secure admission) ☐ Visa ☐ Master Card ☐ American Express ☐ Other:_	Expiry Date (MM/YY):

The cost of your proedure will be forwarded to you by email. Your card will not be charged until your case has been reviewed, accepted and you have accepted the terms and conditions of the care you will receive with us.

For Office Use Only

Date Received:	Special Instructions
Type of Hernia:	
Weight Loss Recommended:	
Surgical Approval:	
Anesthetic Approval:	

INFLUENZA-LIKE ILLNESS(ILI) & ARO/MRSA SCREENING

All patients must complete Section 1 of this form to be considered for admission.

Distant patients submitting medical questionnaires must forward this completed form to NTHRA when submitting the questionnaire.

Failure to follow these procedures may result in delay result in delay or cancellation of surgery.

If there are changes to your health between completing this form and your date of surgery, please contact NTHRA at least 2 weeks before your admission date.
SECTION A
1. Do you have new / worse than usual cough or shortness of breath? ☐ Yes ☐ No 2. Are you feeling feverish, or have you had shakes or chills in the last 24 hours? ☐ Yes ☐ No **If "no" to A1 and 2, proceed to B4 – 8**
3. **Answer #3 only if "yes" to either or both A1 & 2** a) Have you traveled to places outside US/Canada within the last 7 days? ☐ Yes ☐ No
If yes, the country:
b) Have you had contact with a sick person who has traveled outside Canada in the last 7 days? ☐ Yes ☐ No
If yes, the country:
SECTION B
4. Have you been admitted to a hospital for at least 24 hours in the past 12 months? ☐ Yes ☐ No 5. Are you a resident of a Long Term Care facility? (Nursing home, group retirement home, rehab, etc.) ☐ Yes ☐ No 6. Do you work in a facility that has had an outbreak of gastro-intestinal illness or ARO/MRSA within the past year? ☐ Yes ☐ No 7. Have you been on antibiotics within the past year? ☐ Yes ☐ No
If yes, when? / For how long?
8. Have you been told that you have had an " Antibiotic Resistant Organism" such as MRSA, VRE or C-diff ? ☐ Yes ☐ No