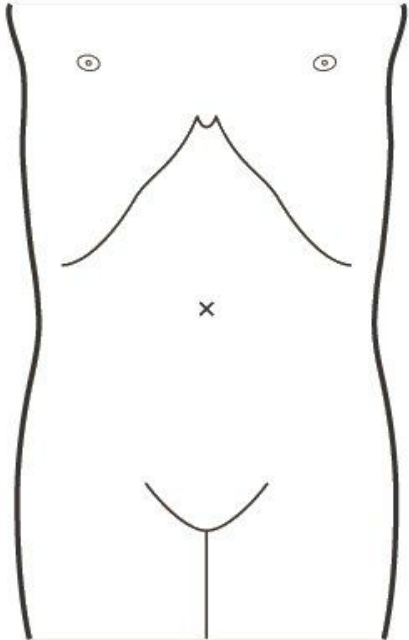


Medical questionnaire for inguinal hernia

First name		Last name	
Gender	<input type="checkbox"/> Man <input type="checkbox"/> Woman	Age	
Birthday	month/day/year	Nationality	

Side	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both sides	Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Duration	<input type="text"/>	Diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other comments			
<input style="width: 100%; height: 30px;" type="text"/>			
Past medical history			
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	when	
Any surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	1.when	<input type="text"/> what <input type="text"/>
		2.when	<input type="text"/> what <input type="text"/>
		3.when	<input type="text"/> what <input type="text"/>
		4.when	<input type="text"/> what <input type="text"/>
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Any other diseases?			
<input style="width: 100%; height: 30px;" type="text"/>			
Any medication? (especially drugs preventing hemostasis)			
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Warfarin	<input type="checkbox"/> Panaldin	<input type="checkbox"/> Plavix
any other drugs?			
<input style="width: 100%; height: 30px;" type="text"/>			
Allergy			
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bandaid	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tropical fruits	<input type="checkbox"/> Yes <input type="checkbox"/> No		



Please mark your bulge in the figure