JONATHAN YUNIS MD FACS
MELANIE WILBER LPN Nurse Administrator
MANDY SCHAAN MS PA-C

1435 South Osprey Avenue Suite 201
Sarasota, Florida 34239
941-953-5917
www.centerforherniarepair.com

Today's Date: ____________________

PATIENT DEMOGRAPHICS

Name: ____
First Middle Last

Male ❑ Female ❑ Date of Birth: ________________ Social Security #: ________________

Marital Status: Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed ❑

Local Address: ____
Street Unit # City State Zip

Preferred Phone: ________________ Other phone: ________________

Out of State Address: ____
Street Unit # City State Zip

Email: ____

EMERGENCY/ALTERNATE CONTACT

Name: ________________ Phone: ________________ Relation: ________________

MEDICAL RECORDS RELEASE – PATIENT PAYMENT – ASSIGNMENT OF BENEFITS

I hereby authorize Center for Hernia Repair (CFHR) to furnish my medical information to insurance carriers, referring physicians and/or any persons I designate. I give permission for any of my medical records, x-rays, other hospital test(s) and/or any additional information contained in my medical records to be sent to CFHR via mail or fax. I also assign CFHR all payments for medical services rendered to myself and/or my dependent(s). I understand that I am responsible for all co-pays and/or balances not covered by my insurance carrier and that all payments are to be rendered at time of service. If my account becomes delinquent and is not resolved in a reasonable amount of time it may be turned over to our outside collection agency Gulf Coast Collection Bureau.

PRIVACY PRACTICES

With my consent, Center for Hernia Repair may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Center for Hernia Repair Notice of Privacy Practices for a more complete description and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Center for Hernia Repair reserves the right to revise its Notice of Privacy Practices at anytime.

With my consent, Center for Hernia Repair may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Center for Hernia Repair may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Center for Hernia Repair may send email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Center for Hernia Repair restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Center for Hernia Repair use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Center for Hernia Repair may decline to provide treatment to me.

______________________________ ________________
Patient Signature Date

____
Printed Name of Patient

CLINICAL INFORMATION

Name: ______________________ **Age:** ________ **Today's Date:** ______________

Please describe the problem or symptom that you are being seen for today:

____

____

How long has this been going on?______________________

Where in your abdomen do you have the complaint? Right Side ❑ Left Side ❑ Central ❑

What makes the symptoms better? ______________________

What makes the symptoms worse?______________________

How often do you experience symptoms from your hernia? Never Occasionally Daily Weekly

On a scale of 1-10 (1 = very little; 10 = severe)

What would you rate your pain? ________

OCCUPATION

Are you currently working? Yes ❑ No ❑ Retired ❑

What kind of work are you doing or did you do in the past? ______________________

FAMILY HISTORY

Is there any family member that has or had a hernia? Yes ❑ No ❑

If yes, relation? ______________________Age of onset?______________

Please list your mother's and father's medical diagnoses and/or cause of death (if known):

Mother______________________Father ______________________

SOCIAL HISTORY

Do you currently smoke cigarettes, vape or e-cigs Yes ❑ No ❑

Did you quit smoking – Less than 1 month ago Less than 1 year ago Greater than 1 year ago

Please list physical activities that you engage in greater than 2 times per week:

____

____

SURGICAL HISTORY

Have you had previous hernia surgery? Yes ❑ No ❑

Type of Hernia Repair: ______________________ **DATE:** __________

Type of Hernia Repair: ______________________ **DATE:** __________

Type of Hernia Repair: ______________________ **DATE:** __________

Type of Hernia Repair: ______________________ **DATE:** __________

Please list any other operations you have had below:

Year		Operation	
Year		Operation	
Year		Operation	
Year		Operation	
Year		Operation	
Year		Operation	
Year		Operation	

PAST MEDICAL HISTORY

Please **MARK** if you have been **DIAGNOSED** with any of the following conditions:

- **Hypertension – High Blood Pressure** ❑
- **Diabetes** ❑
- **COPD / Emphysema / Sleep Apnea** ❑
- **Liver Disease / Cirrhosis / Ascites** ❑
- **Kidney Disease** or **Renal Insufficiency** ❑
- **MRSA / C Diff** ❑
- **Coronary Artery Disease / Heart Attack / CHF** ❑
- **Atrial Fibrillation / Arrhythmia** ❑
- **Aortic Aneurysm** ❑
- **Bleeding Problem** ❑
- **Deep Venous Thrombosis / Pulmonary Embolism** ❑
- **Cancer – Type:** ______________________ ❑
- **Other** ______________________ ❑

Please **MARK** below procedures that you have had in the past:

- **Pacemaker** ❑
- **Heart Bypass** ❑
- **Heart (Coronary Artery) Stent** ❑
- **If so, when?** ______________________
- **AICD** ❑
- **Valve Replacement** ❑

CENTER FOR HERNIA REPAIR

MEDICATIONS

Medication		Dose		Times per Day	
Medication		Dose		Times per Day	
Medication		Dose		Times per Day	
Medication		Dose		Times per Day	
Medication		Dose		Times per Day	
Medication		Dose		Times per Day	
Medication		Dose		Times per Day	
Medication		Dose		Times per Day	

Pharmacy of Choice____

ALLERGIES

List any medicine that you are allergic to (if any):

Medicine		Reaction	
Medicine		Reaction	
I have no allergies to any medications ❑			

Please **MARK** if you have experienced any of the following symptoms in the **LAST 3 MONTHS**:

Unintended Weight Loss	❑	Frequent Nausea	❑	Bleeding Problem(s)	❑
Fever or Chills of Unknown Cause	❑	Frequent Vomiting	❑	Recent Abdominal Pain	❑
Chest Pain	❑	Blood in Stool	❑	Trouble Urinating	❑
Shortness of Breath	❑	Change in Bowel Habits	❑	Awakening from Sleep to Urinate more than 3 Times a night	❑