**JONATHAN YUNIS MD FACS**
**RALPH DECAPUA PA-C**
**MELANIE WILBER, Nurse Administrator**

Today's Date:_____

## GENERAL INFORMATION

Name: _____
First Middle Last

Male ❑ Female ❑ Date of Birth_____Social Security #:_____

Local Address: _____

Phone: _____ Cell Phone: _____Preferred Phone:_____

Out of State Address: _____

Marital Status: Married ❑ Single ❑ Partnered ❑ Email: _____

Race/Ethnicity ***(We are required to ask this question by the U.S. Government)***: American Indian ❑
Alaskan Native ❑ Hawaiian or Pacific Islander ❑ Black ❑ Hispanic ❑ White-not of Hispanic Origin ❑

Primary Physician:_____Phone:_____

Referring Physician:_____Phone:_____
(or referral source): ❑ Internet ❑ Friend ❑ News Media ❑ Other: _____

Other Physician: _____Phone:_____

## EMERGENCY/ALTERNATE CONTACT

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

## INSURANCE INFORMATION

Primary Carrier:_____

Secondary Carrier: _____

**If you are <u>NOT</u> the primary card holder, please fill out:**

Policy Holder's Name:_____ Date of Birth: _____ Relationship:_____

*It is ultimately the patient's responsibility to understand their insurance policy and benefits.*

## 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.

Signature: _____Date: _____

CENTER FOR HERNIA REPAIR

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

CENTER FOR HERNIA REPAIR

Name: _____ Age: _____ Today's Date: _____

## PATIENT CLINICAL HISTORY FORM

Why are you here to see the surgeon today?_____

_____

_____

## DETAILS OF YOUR PROBLEM

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? _____

Were you diagnosed with a hernia by a medical professional? Yes ❑ No ❑

If yes, who?_____ When?_____

Do you have pain or discomfort from your hernia? Yes ❑ No ❑

How often do you experience symptoms from your hernia?

Never ❑ Occasionally ❑ Daily ❑ Weekly ❑ Monthly ❑

## PAIN/DISCOMFORT

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

What would you rate your pain? _____

What would you rate your pain or discomfort for most of a typical day? _____

What would you rate your pain or discomfort when it is at its worst? _____

## OCCUPATION

Are you currently working? Yes ❑ No ❑ Retired ❑

What is your occupation? _____ Does your job involve significant lifting? Yes ❑ No ❑

If you are retired, what was your occupation?_____

## FAMILY HISTORY

Is there any family member(s) 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 _____

CENTER FOR HERNIA REPAIR

## SOCIAL HISTORY

Do you currently smoke cigarettes or cigars? Yes ❑ No ❑

Have you quit smoking in the past year? Yes ❑ No ❑ If yes, how many years ago did you quit? _____

Do you drink alcoholic beverages? Yes ❑ No ❑ If yes, how many on an average day? _____

## CHECK THE ACTIVITIES BELOW THAT YOU PARTICIPATE IN ON A FREQUENT BASIS

| | | | |
|---|---|---|---|
| | **Walking** – Avg. Distance / Duration: | | **Boxing** |
| | **Running** – Avg. Distance / Duration: | | **Kickboxing** |
| | **Cycling** – Avg. Distance / Duration: | | **Martial Arts** – Type: |
| | **Swimming** – Avg. Distance / Duration: | | **Yoga** |
| | **Rowing** – Avg. Distance / Duration: | | **Golf** – Times per Week: |
| | **Kayaking** – Avg. Distance / Duration: | | **Tennis** – Times per Week: |
| | **Weight Training** | | **Basketball** |
| | **Circuit Training** | | **Baseball** |
| | **Crossfit Training** | | **Volleyball** |
| | **Dancing** | | **Other:** |

## PAST SURGICAL HISTORY

Have you had previous hernia surgery? Yes ❑ No ❑

Type of Hernia Repair: _____ Approximate Year: _____

Type of Hernia Repair: _____ Approximate Year: _____

Type of Hernia Repair: _____ Approximate Year: _____

Type of Hernia Repair: _____ Approximate Year: _____

Please list any other operations that you have undergone:

| | | | |
|---|---|---|---|
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |
| **Year** | | **Operation** | |

CENTER FOR HERNIA REPAIR

## CHECK ANY OF THE FOLLOWING MEDICATIONS YOU ARE CURRENTLY TAKING (IF ANY)

| | | | |
|---|---|---|---|
| ☐ | **Warfarin, Coumadin** or **Jantoven** – Dose: | ☐ | **Hydrocortisone** |
| ☐ | **Eliquis** – Dose: | ☐ | **Methotrexate** |
| ☐ | **Xarelto** – Dose: | ☐ | **Anti-Rejection Medication after Organ Transplant** – Name: |
| ☐ | **Plavix** or **Clopidogrel** | ☐ | |
| ☐ | **Efient**, **Prasugrel** or **Brilinta** | ☐ | **Embrel** |
| ☐ | **Aspirin** | ☐ | **Humira** |
| ☐ | **Steroids** | ☐ | **Remicade** |
| ☐ | **Prednisone** | ☐ | |

Please list all other medications that you take (if any):

| | | | | | |
|---|---|---|---|---|---|
| **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** | |
| **Medication** | | **Dose** | | **Times per Day** | |
| **Medication** | | **Dose** | | **Times per Day** | |

## ALLERGIES

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

| | | | |
|---|---|---|---|
| **Medicine** | | **Reaction** | |
| **Medicine** | | **Reaction** | |
| **Medicine** | | **Reaction** | |
| **Medicine** | | **Reaction** | |

**I have no allergies to any medications** ☐

CENTER FOR HERNIA REPAIR

## PAST MEDICAL HISTORY

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

| | | | |
|---|---|---|---|
| ☐ | **Hypertension – High Blood Pressure** | ☐ | **Heart Valve Problem** |
| ☐ | **Diabetes** | ☐ | **Atrial Fibrillation** |
| ☐ | **COPD** or **Emphysema** | ☐ | **Other Heart Arrhythmia** |
| ☐ | **Sleep Apnea** | ☐ | **Pacemaker** |
| ☐ | **Kidney Disease** or **Renal Insufficiency** | ☐ | **AICD** |
| ☐ | **Kidney Disease with Need for Dialysis** | ☐ | **Heart Surgery** |
| ☐ | **Arthritis** | ☐ | **Stent** |
| ☐ | **Crohn's Disease** or **Ulcerative Colitis** | ☐ | **Deep Venous Thrombosis/PE** |
| ☐ | **Diverticulitis** | ☐ | **Bleeding Problem** |
| ☐ | **Gerd** or **Gastro Esophageal Reflux** | ☐ | **Anemia** |
| ☐ | **Gallbladder Problem** | ☐ | **Peripheral Vascular Disease** |
| ☐ | **Liver Disease, Hepatitis** or **Cirrhosis** | ☐ | **Carotid Stenosis** |
| ☐ | **Bowel Obstruction** | ☐ | **Stroke** |
| ☐ | **Heart Attack** | ☐ | **Seizure Disorder** |
| ☐ | **Coronary Artery Disease** | ☐ | **Cancer** – Type: |
| ☐ | **Aortic Aneurysm** | ☐ | **MRSA** |

Have you had any problem with anesthesia? Yes ❑ No ❑ If yes, what? _____

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

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **Weight Loss Greater than 10 Pounds** | ☐ | **Nausea** | ☐ | **Back pain** |
| | How many pounds? | ☐ | **Vomiting** | ☐ | **Joint Pain** – Which? |
| | Over what period of time? | ☐ | **Blood in Stool** | | |
| ☐ | **Fever** or **Chills of Unknown Cause** | ☐ | **Constipation** | ☐ | **Pain in Extremity** – Which? |
| ☐ | **Chest Pain** | ☐ | **Diarrhea** | | |
| ☐ | **Irregular Heart Beat** | ☐ | **Trouble Urinating** | ☐ | **Loss of Consciousness** |
| ☐ | **Shortness of Breath** | ☐ | **Painful Urination** | ☐ | **Seizure** |
| ☐ | **Bleeding Problem(s)** | ☐ | **Awaking from Sleep to Urinate** | ☐ | **Freq. Severe Headaches** |
| ☐ | **Easy Bruisability** | | **more than 2 Times per Night** | ☐ | **Loss of Vision** |
| ☐ | **Abdominal Pain** | ☐ | **Other:** | | |

Are you interested in improving the appearance of your abdomen with an abdominoplasty (tummy tuck)? Yes ❑ No ❑

Are you interested in improving the appearance of your belly button with an umbilicoplasty? Yes ❑ No ❑

Are you interested in a vasectomy through the same surgical incision as the hernia repair? Yes ❑ No ❑