Name: _____ Date of Birth: _____

Address: _____

_____

Cell phone number: _____

Secondary number: _____

Email address: _____

3370 Burns Road, Suite 100
Palm Beach Gardens Florida, 33410
(561) 513-9806 p / hello@seasidehernia.com

Seaside HERNIA CENTER

Reason for visit _____

Duration of problem _____location_____

Severity (please circle) MILD MODERATE SEVERE

Please circle any associated symptoms

NAUSEA VOMITING FEVER CHEST PAIN SHORTNESS OF BREATH

Please list past medical and surgical history below

_____

_____

_____

_____

_____

_____

Current medications _____

_____

_____

Allergies _____

_____

_____

Family history _____

_____

Current social history - please circle:

1- Alcohol use: YES NO

2- Nicotine use: YES NO

If yes, CURRENT FORMER (within a year) DISTANT (greater than 1 yr)

Type SMOKING E-CIGARETTE CHEW PATCH GUM

3- Type of employment: no employment desk based light physical labor

moderate physical labor heavy physical labor

4- Sporting/exercise: none sporadic (1x month) moderate (1xweek)

Intense (greater than 1x week)

Review of Systems. Please circle any that apply to you.

General:

Fever or night sweats Fatigue Sore throat

Asthma Hearing loss Glaucoma

Recent weight loss	Double Vision	Nose bleeds
Swollen glands	Sinus problems	Cough
Changes in vision		

Cardiovascular:

High blood pressure	Arrhythmia	Phlebitis
Heart problems	Pedal edema	Heart attack
Unable to walk up stairs	PND	Chest pain

Gastrointestinal:

Abdominal pain	Vomiting	Heartburn
Bowel incontinence	Nausea	Diarrhea
Indigestion	Change in bowels	Constipation
Difficulty swallowing		

Urology:

Blood in urine	Urine hesitancy	Kidney stones	Sexual dysfunction
Weak urine stream	Painful urination	Menstrual problems	
Testicular pain	Daytime urinary frequency	Nighttime urinary frequency	

Musculoskeletal and Neurological:

Arthritis	Muscle Pain	Joint pain and swelling
Back pain/injuries	Numbness/tingling	Claudication
Weakness	Seizure	Headaches/dizziness
Head injury	Stroke	Paralysis/tremors

Psychiatric:

Difficulty sleeping	Depression	Manic episodes
Schizophrenia		

Hematologic/Lymphatic

Anemia	Easy to bruise or bleed	Slow to heal after cuts
Enlarged gland		

Endocrine:

Thyroid disease	Heat/Cold intolerance	Excessive thirst
Diabetes	Excessive urination	Changes in hair

Integumentary:

Breast pain or discharge	Change in skin color	Rashes
Change in hair or nails	Itching	Varicose veins

Please list any other information you wish to share below:

Consent to treat and financial agreement

I consent to treatment, diagnostic, and or therapeutic treatment from Dr. David Coykendall. I agree to pay all copays, deductibles, and other charges *before the date of surgery.* I authorize payments directly to Dr. Coykendall of all such insurance benefits payable to me. I authorize the doctor to release my medical information to such insurance companies as is necessary to receive payment for services rendered.

I understand that Dr. Coykendall and his staff may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring treatments, for obtaining payments for services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment, and healthcare operations.

I understand that all consultation fees are *nonrefundable*. I understand that self pay paints are required to pay the doctor before surgery.

PRINTED NAME _____

SIGNATURE _____/DATE_____