Boston Hernia and Pilonidal Center
Patient Medical History Form

Name: _____ Date of Birth: _____

Primary Care Doctor: _____

Occupation: _____
Are you here because of a work related injury? **YES NO**

Do you smoke? **YES NO**
Do you drink alcohol? **YES NO**

MEDICAL HISTORY:

Medical Problem ***Year***

_____
_____
_____
_____
_____

SURGICAL HISTORY:

Operation ***Year***

_____
_____
_____
_____
_____

CURRENT MEDICATIONS:

Name ***Dosage***

_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____