Boston Hernia & Pilonidal Center
Patient Medical History Form

Name: _____ Date of Birth: _____

Primary Care Doctor: _____

Occupation: _____

Who Referred you?_____

Are you here because of a work related injury? **YES NO**
Do you smoke? **YES NO**
Do you drink alcohol? **YES NO**
Any history of substance use disorder including misuse of opioids in the past? **YES NO**

MEDICAL HISTORY:

Medical Problem ***Year***

_____
_____
_____
_____
_____

SURGICAL HISTORY:

Operation ***Year***

_____
_____
_____
_____
_____

CURRENT MEDICATIONS:

Name ***Dosage***

_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____

Please fill out the back of this form

Boston Hernia & Pilonidal Center
Patient Medical History Form

Please check the box next to any of the below symptoms that you are currently experiencing.

Constitutional

- ❑ Activity Change
- ❑ Appetite Change
- ❑ Chills
- ❑ Diaphoresis
- ❑ Fatigue
- ❑ Fever

HENT

- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Sore throat
- ❑ Trouble swallowing
- ❑ Sneezing
- ❑ Sinus pressure
- ❑ Congestion

Respiratory

- ❑ Apnea
- ❑ Chest tightness
- ❑ Cough
- ❑ Shortness of breath

Cardiovascular

- ❑ Chest pain
- ❑ Leg swelling
- ❑ Palpitations

GI

- ❑ Abdominal distention
- ❑ Abdominal pain
- ❑ Blood in stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting

GU

- ❑ Difficulty urinating
- ❑ Nocturia
- ❑ Dysuria
- ❑ Pelvic pain
- ❑ Flank pain
- ❑ Frequency
- ❑ Urgency
- ❑ Incontinence

Musculoskeletal

- ❑ Arthralgias
- ❑ Myalgias
- ❑ Back pain
- ❑ Joint swelling

Skin

- ❑ Rash
- ❑ Wound

Neurological

- ❑ Dizziness
- ❑ Weakness
- ❑ Headaches
- ❑ Light-headedness
- ❑ Seizures
- ❑ Syncope

Psychiatry

- ❑ Agitation
- ❑ Behavior problem
- ❑ Confusion
- ❑ Decreased concentration
- ❑ Hyperactive
- ❑ Nervous/anxious