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**

Height: _____ft _____in Weight: __________lbs

MEDICAL HISTORY:
Medical Problem ***Year***

____
____
____
____

SURGICAL HISTORY:
Operation ***Year***

____
____
____
____

CURRENT MEDICATIONS:
Name ***Dosage***

____
____
____
____

ALLERGIES :

____
____
____

Please fill out the back of this form

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Please circle any of the symptoms you are 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