

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***

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**SURGICAL HISTORY:**

***Operation***      ***Year***

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**CURRENT MEDICATIONS:**

***Name***      ***Dosage***

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**ALLERGIES :**

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***Please fill out the back of this form***

Boston Hernia & Pilonidal Center  
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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