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:**

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________