	Date:

PILONIDAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential & are used for informational purposes only.

Name (Last, First, M.I.):			☐ **M**	☐ **F**	**Age:**
Status:	☐ Student	☐ Office work	☐ Physical work	☐ Long commute	☐ Travel required
Other person who is available to help with care:	☐ None	☐ Spouse	☐ Parent	☐ Friend	☐ Other

TELL ME ABOUT YOURSELF

Check off any medical conditions that apply:	☐ Problems with anesthesia	☐ History of blood clots	☐ Bleeding problems
	☐ Hepatitis / HIV	☐ MRSA infection	☐ Other

List any other medical problems that you have been treated for:

Previous surgery (not pilonidal) that you have had:

Year	Reason	Year	Reason

List your prescribed drugs	**Allergies to medications**	
Name the Drug	Name the drug	Reaction You Had

Tell me about your pilonidal			
Check off any complaints that apply:	☐ Swelling	☐ Drainage	☐ Bleeding
	☐ Pain with sitting / working	☐ Pain / interferes with activities	☐ Fever / Infection
	☐ Embarrassing	☐ Staining clothing	☐ other
Duration of symptoms:	☐ weeks	☐ months	☐ years
Frequency of symptoms:	☐ Occasional	☐ Frequent	☐ Constant
Severity of symptoms:	☐ Mild	☐ Moderate	☐ Severe
	☐ Improving	☐ Worsening	☐ Unchanged

Additional history:	# of previous episodes	# of previous drainage procedures	# of previous surgeries
Prior treatment:	☐ No previous treatment	☐ Antibiotics only	☐ Incision & drainage
	☐ Removed & left open	☐ Removed & closed	☐ Hair removal
	☐ Cauterization	☐ Packing	☐ Other

Thank you for providing more information that will help me best care for you.

Please save & email this completed form to info@pilonidalsurgeon.com.
This email is HIPPA compliant.
You can also print and fax to 856-428-2718.

A member of my staff will contact you to schedule an appointment.

Eytan Irwin,MD FACS, FASCRS
www.PilonidalSurgeon.com

SAVE FILE PRINT CLEAR FORM