Pilonidal Disease Patient Intake Form | Non-BC Residents Only

Name:

Age:

Height : ft in

Weight: pounds

Address:

Email:

Phone number:

How long have you had pilonidal disease?

If applicable, indicate past surgeries:

☐ Pit Picking

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Gips Procedure

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ ESPiT (Endoscopic Pilonidal Sinus Treatment)

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Excision with Open Healing

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Excision with Primary Closure

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Bascom Cleft Lift

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Modified Karydakis

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Limberg Flap

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Z-Plasty

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Rotational Flap

Date(s) of surgery/surgeries (m/d/y):

Location(s):

☐ Incision and drainage of pilonidal abscesses (e.g. in the emergency department)

Date(s) of surgery/surgeries (m/d/y):

Location(s):

If you have been treated with antibiotics for pilonidal disease, what dates? (m/d/y):

If you are on any medications, please list:

If you have any major medical co-morbidities, please list:

If you have had any other operations, please list:

If you have any drug allergies, please list:

Tobacco use/e-cigarettes status:

- ☐ Current
- ☐ Former
- ☐ Never

Additional comments:

Once completed, fax to **604 534 9958**, and we will contact you. Please note that the submission of this form does not constitute as a formal referral. If appropriate, the patient will be instructed to seek a referral from their family physician.