THE STERNBERG CLINIC
surgeons who listen

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Updated 2.01.2022

New-Pilonidal Patient Questionnaire

If you are a new patient and live outside of the San Francisco Bay Area, please fill out the form below and email it to our staff at the Sternberg Clinic Sternberg info@thesternbergclinic.com prior to making an appointment with Dr. Jeffrey Sternberg. This will provide our team with a concise history of your Pilonidal Disease story. Sending this well in advance of your visit gives our team adequate time to understand your case and make the most of your visit to our San Francisco medical clinic.

Physical Exam: If you have any significant medical issues (e.g., Asthma, high blood pressure, heart issues, kidney issues, obesity, diabetes....) you should have a history and physical exam from your local primary doctor prior to traveling to San Francisco but within one month of your scheduled surgery. Dr. Sternberg's office will assist your medical clearance if needed.

Name _____ Nickname _____

Sex: Male Female

Preferred Pronouns: _____

Personal Information and Contact Information:

How Old Are You? _____ years old Date of birth: _____

Where do you live: _____ Home

Address (associated with your insurance card):

_____

_____

Cell Phone Number: _____

Email Address: _____

Your Travel Companion:

Name: _____ Relationship: _____

Companion's Cell Phone Number: _____ **Primary**

Care Physician or Pediatrician:

Physician's Name:

_____

Address: _____

Phone Number: _____

Questions about your pilonidal problem:

When did you first notice the condition? _____year(s) _____ month(s) ago

Have you required any office or emergency room drainage procedures? ___ NO ___ YES

If, "Yes" how many times? _____

Has your Pilonidal Disease required operations in an operating room? ___ NO ___ YES

If, "Yes" how many times? _____

Please List your Pilonidal operations:

1. Date: _____, location: _____, Surgeon:_____

2. Date: _____, location: _____, Surgeon:_____

3. Date: _____, location: _____, Surgeon:_____

Did you find us on your own? Y/N What

search terms did you use?

_____

Did someone refer you to the Sternberg Clinic? _____

Have you required wound care? Y/N For how long: _____ Months

Have you ever had a 'Wound Vac'? ___ NO ___ YES If yes, For how long? _____ Months

IMPORTANT: Have you been on more than one course of antibiotics in the last year for your pilonidal problem? ___ NO ___ YES

If yes, do you have an open or persistently draining wound? ____ NO ____ YES

If yes, you may need to have a bacterial culture with sensitivities of the wound performed (within two months of your scheduled surgery) and sent to us at least two weeks before your trip. We will let you know.

Additional Medical Information:

Please list any medical conditions you have:

Please list any other operations you have had unrelated to your Pilonidal Disease:

Please list any medications that you take regularly:

Please list any **drug allergies** you may have:

Please list your accurate height and weight: No cheating, please. Accuracy is essential. If you're your BMI is close to or greater than 40 you will be required to lose weight prior to travel for surgery. Here's a link to a BMI calculator.

Height: _____ ft/in Weight: _____ lbs. BMI: _____

In addition to this form, please include a photo of the front and back of your Insurance Card Also include TWO PHOTOS of your bottom taken by someone who can see your Pilonidal Disease wound clearly. (Yes, another person: no cheating.) It's impossible for you to take adequate photos on your own. For instructions on how to take the proper photos please click here.

Important for arranging surgery:

Have you and your companion both been vaccinated against SARS COVID-2? If you meet the criteria established by the State of California, you may not need to be COVID tested prior to surgery. These rules may change as case numbers change every week.

Patient: Vaccine (Pfizer, Moderna, J&J*). Date of 1st dose_____,

2nd dose_____, Booster_____,

Companion: (Pfizer, Moderna, J&J*). Date of 1st dose_____,

2nd dose_____, Booster_____,

Please email this form to info@thesternbergclinic.com. In the subject line please include your name and the words "new patient inquiry". Our email is HIPAA-compliant.