Print Form

PILONIDAL CYST INTERVIEWW FORM

Patient name _____ Date _____

1. When did you first notice the cyst? _____
   _____
2. Does it cause any discomfort? Yes ◯ No ◯

   If yes, does anything make it worse? _____
   _____
   _____
   _____
3. Does anything make it better?_____
   _____
   _____
   _____
4. Have you noticed any drainage? Yes ◯ No ◯

   Color of drainage? _____

   How long does it drain? _____
5. Has anyone ever lanced the cyst? Yes ◯ No ◯

   If so, when? _____
6. Have you ever been prescribed antibiotics for the cyst? Yes ◯ No ◯

   If so, what antibiotic? _____