Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Surgeries

Please answer every question.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

Please mark all surgeries you have had.

◯ **I have had NO SURGERIES** *(No need to complete questionnaire.)*

◯ **Anal Fissure Repair**	◯ **Low Back Disc Surgery**	◯ **Tonsillectomy**	◯ **Deviated Nose Septum**
◯ **Appendectomy**	◯ **Neck Disc Surgery**	◯ **Ulcer Surgery**	◯ **Tubal Ligation**
◯ **Hemorrhoidectomy**	◯ **Sinus Surgery**	◯ **Vasectomy**	

Prostate Surgery	◯ TURP	◯ Removal		
Gallbladder Surgery	◯ Open	◯ Laparoscopic		
Colon Polyp Removal	◯ Open	◯ Colonoscopy		
Colon Removal	◯ Partial	◯ Complete		
Hysterectomy *(due to cancer)*	◯ Partial	◯ Complete		
Hysterectomy *(not due to cancer)*	◯ Partial	◯ Complete		
Spinal Fusion	◯ Neck	◯ Lower Back		
Spinal Decompression	◯ Neck	◯ Lower Back		
Dilation and Curettage (D&C)	◯ Single	◯ Multiple		
Lung Surgery	◯ Left	◯ Right	◯ Both	
Kidney Removal	◯ Left	◯ Right	◯ Both	
Cataract Surgery	◯ Left	◯ Right	◯ Both	
Breast Cancer Lump Removal	◯ Left	◯ Right	◯ Both	
Mastectomy	◯ Left	◯ Right	◯ Both	
Breast Reconstruction	◯ Left	◯ Right	◯ Both	
Breast Reduction	◯ Left	◯ Right	◯ Both	
Ovary Removal	◯ Left	◯ Right	◯ Both	
Carpal Tunnel Surgery	◯ Left	◯ Right	◯ Both	
Rotator Cuff Repair	◯ Left	◯ Right	◯ Both	
Arthroscopic Shoulder Surgery	◯ Left	◯ Right	◯ Both	
Hip Fracture & Surgery	◯ Left	◯ Right	◯ Both	
Total Hip Replacement	◯ Left	◯ Right	◯ Both	
Total Knee Replacement	◯ Left	◯ Right	◯ Both	
Arthroscopic Knee Surgery	◯ Left	◯ Right	◯ Both	
Foot Surgery	◯ Left	◯ Right	◯ Both	
Varicose Vein Procedure	◯ Left	◯ Right	◯ Both	
Mastoidectomy	◯ Left	◯ Right	◯ Both	
Thyroid Removal	◯ Left	◯ Right	◯ Total	◯ Partial
Breast Biopsy	◯ Left	◯ Right	◯ Both	◯ Multiple times
Carotid Artery Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Open Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Laparoscopic Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Caesarean Section	◯ 1	◯ 2	◯ 3 or More	
Heart Valve Replacement	◯ Mitral	◯ Aortic	◯ Tricuspid	◯ Unknown Valve
Heart Bypass Surgery	◯ 1 Vessel	◯ 2 Vessels	◯ 3 Vessels	◯ 4 or More Vessels
	◯ Unknown Number of Vessels			

◯ **Other Surgery** *If yes, please specify type, where and when*:

_____

_____

Have you ever been hospitalized? ◯ Yes ◯ No

If yes, please specify where and when:

_____

_____