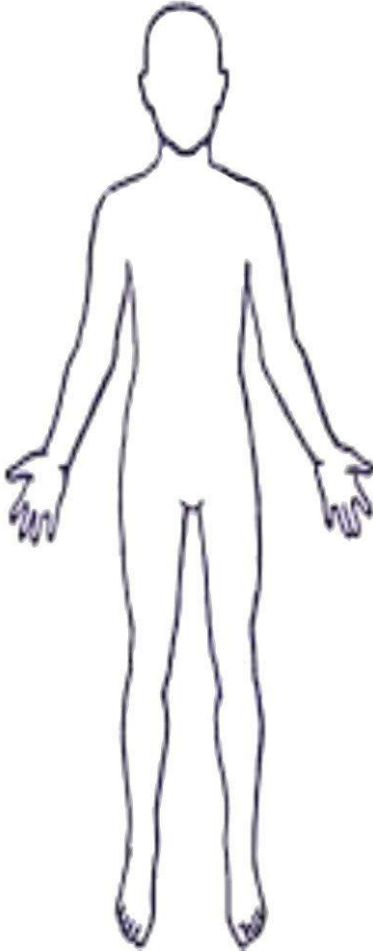


Operations

Check ANY that apply



| Illness | Details if needed | Date(s) if you recall |
|--|---|--------------------------|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | |
| <input type="checkbox"/> Sinus Surgery | | |
| <input type="checkbox"/> Tonsillectomy | | |
| <input type="checkbox"/> Disc Surgery | <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbosacral | |
| <input type="checkbox"/> Breast Surgery/biopsy | | |
| <input type="checkbox"/> Cardiac Bypass | | |
| <input type="checkbox"/> Pacemaker/AICD | | |
| <input type="checkbox"/> Lung Surgery/biopsy | | |
| <input type="checkbox"/> Ulcer Surgery | | |
| <input type="checkbox"/> Gallbladder | | |
| <input type="checkbox"/> Appendectomy | | |
| <input type="checkbox"/> Splenectomy | | |
| <input type="checkbox"/> Kidney Surgery | | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hiatal <input type="checkbox"/> Inguinal <input type="checkbox"/> Both | |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both | |
| <input type="checkbox"/> Bladder Surgery | | |
| <input type="checkbox"/> Hysterectomy | | |
| <input type="checkbox"/> Ovary Surgery | | |
| <input type="checkbox"/> Prostate Surgery | | |
| <input type="checkbox"/> Vasectomy | | |
| <input type="checkbox"/> Colon Surgery | | |
| <input type="checkbox"/> Hemorrhoidectomy | | |
| <input type="checkbox"/> Arthroscopy(s) | | |

List involved joints: _____

Other, not listed above:

Patient Signature or Initials