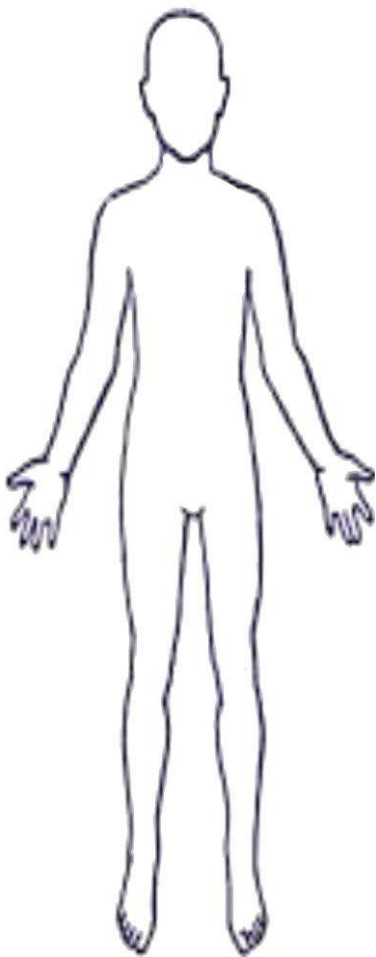


## **SURGICAL HISTORY**

Check ANY that apply



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

Other, not listed above:

---



---



---



---



---

\_\_\_\_\_  
 Patient Signature or Initials