

PAST SURGICAL HISTORY

Have you ever had?	Check Only Those That Apply Circle Where Appropriate	Have you ever had?
General:	Thorasic:	Genito-Urinary:
<input type="checkbox"/>	<input type="checkbox"/> Lung	<input type="checkbox"/> Turp (Prostate surgery)
<input type="checkbox"/>	<input type="checkbox"/> Pneumonectomy (Removal of Lung)	<input type="checkbox"/> Suprapubic Prostatectomy
Skin & Subcutaneous Tissue:	<input type="checkbox"/>	<input type="checkbox"/> Urinary Bladder stone removal
<input type="checkbox"/> Cyst removal	Cardiac:	<input type="checkbox"/> Urinary Bladder cancer
<input type="checkbox"/> Skin cancer	<input type="checkbox"/> CABG	<input type="checkbox"/> Nephrectomy (Removal of Kidney)
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Coronary Stent	<input type="checkbox"/> Penile implant
<input type="checkbox"/> Lipoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Genital warts
		<input type="checkbox"/> Urinary Bladder suspension
Head & Neck:	<input type="checkbox"/> Peripheral Vascular:	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Tonsilectomy & Adenoidectomy	<input type="checkbox"/> Abdominal aortic aneurysm	
<input type="checkbox"/> Vocal cord polyp	<input type="checkbox"/> Femoral popliteal bypass	Gastrointestinal:
	<input type="checkbox"/>	<input type="checkbox"/> Appendectomy
Eyes:	<input type="checkbox"/> Varicose veins surgery	<input type="checkbox"/> Cholecystectomy open (Removal of Gallbladder)
<input type="checkbox"/> Cataract Extraction		<input type="checkbox"/> Cholecystectomy, laparoscopic
	Musculoskeletal:	<input type="checkbox"/> Common duct exploration, stones
Neck:	<input type="checkbox"/> Hernia <input type="checkbox"/> Left <input type="checkbox"/> Right ?	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Thyroidectomy	<input type="checkbox"/> Hernia, inguinal <input type="checkbox"/> Left <input type="checkbox"/> Right ?	<input type="checkbox"/> Gastrectomy / (Removal of Stomach)
<input type="checkbox"/> Parathyroidectomy	<input type="checkbox"/> Hernia, umbilical	<input type="checkbox"/> for ulcers / cancer
	<input type="checkbox"/> Hernia, femoral <input type="checkbox"/> Left <input type="checkbox"/> Right ?	<input type="checkbox"/> Colectomy / (Removal of Colon)
Oral:	<input type="checkbox"/> Hernia, other	<input type="checkbox"/> for diverticulitis / cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hiatal hernia
	Orthopedic:	<input type="checkbox"/> Hemorrhoidectomy
Breast:	<input type="checkbox"/> Fracture of:	<input type="checkbox"/>
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Fracture of:	<input type="checkbox"/>
<input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Fracture of:	<input type="checkbox"/> Pancreatectomy (Removal of Pancreas)
<input type="checkbox"/> Mastectomy (Removal of Breast)	<input type="checkbox"/> Carpal tunnel repair	
<input type="checkbox"/> Axillary dissection	<input type="checkbox"/> Knee Arthroscopy/Replacement: L R	Gynecology:
	<input type="checkbox"/> Hip Replacement <input type="checkbox"/> Left <input type="checkbox"/> Right ?	<input type="checkbox"/> C-section
Plastic surgery:	<input type="checkbox"/> Rotator cuff	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> abdominal/ <input type="checkbox"/> vaginal
<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Spinal	<input type="checkbox"/> Oophorectomy-ovary <input type="checkbox"/> R / <input type="checkbox"/> L
<input type="checkbox"/> Breast reduction		<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Breast implants	Other	<input type="checkbox"/> Uterine suspension
<input type="checkbox"/> Face lift	<input type="checkbox"/> Splenectomy	
<input type="checkbox"/> Abdominal lipectomy		

I refuse to fill this out

Signature _____

Date _____

Remember! If you do not give me a complete and accurate history,

I cannot give you a complete and accurate diagnosis and treatment!