

Your Surgical History

Your name:(printed) _____

Today's Date: _____

No Surgical History ()

Procedure	Yes (x)	Year	Code	Comment
Abdominal Surgery				
Appendectomy				
Back(cervical)				
Back(lumbar)				
Biopsy(location)				
Breast Biopsy				Circle Left Right Both
Breast Surgery				Circle Left Right Both
Colonoscopy				
Coronary Artery Bypass(CABAG)				
Coronary Stent				
Stomach Endoscopy (EGD)				
Cataract				
Foot Surgery				we will discuss
Gallbladder Removal				Circle Laparoscopic
Heart Surgery (not CABAG)				
Hip Surgery				Circle Left Right Both
Hysterectomy (total)				Circle Laparoscopic Vaginal Abdominal
Hysterectomy (partial)				Circle Laparoscopic Vaginal Abdominal
Knee Surgery (arthroscopic)				Circle Left Right Both
Knee Surgery (total)				Circle Left Right Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation				Circle Left Right Both
Vasectomy				
Plastic Surgery				
Other				
Other				

To the best of my recollection this is a complete record of surgical history

Signature: _____