



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

PAST SURGICAL HISTORY

Display Name- 6 Months: Past Surgical History

Surgical History

Have you ever had any type of Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No(If No, Skip to end of questionnaire)
Surgical History Record all past surgeries	Surgery Type/Date/Age at Surgery _____
Were there any additional surgeries?	Surgery Type/Date/Age at Surgery _____

Thank You for Completing this Questionnaire!

For Research Coordinator use only: CRF was: Self-administered Interviewer-administered