[Study Name/ID pre-filled] Site Name:

Subject ID:

**All the elements on this form are Supplemental (use dependent on study type and design).**

**Surgical History**

1. Has the participant had any surgical procedures?

Yes

No

Don’t Know

No Answer

1. Tonsillectomy

Yes

No

* 1. If yes, date performed \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)

1. Adenoidectomy
   1. If yes, date performed \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)
2. *Splenectomy* Yes

No

Don’t Know

No Answer

1. *Cholecystectomy* Yes

No

Don’t Know

No Answer

1. *Hip Core Procedure* Yes

No

Don’t Know

No Answer

1. *Hip Replacement* Yes

No

Don’t Know

No Answer

Study Name/ID pre-filled] Site Name:

Subject ID:

1. Other  
    Yes

No

Don’t Know

No Answer

* 1. If yes,
  2. Date(s) performed \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ (DD-MMM-YYYY)