[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)