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 SURVEY LIST

SURVEY TITLE

Your Health History



1 Have you ever had a form of heart disease?

HINT TEXT

HEART DISEASE DESCRIBES A RANGE OF CONDITIONS, SUCH AS, CONGESTIVE HEART FAILURE, VALVULAR HEART DISEASE, ARRHYTHMIA, CORONARY HEART DISEASE, OR ATRIAL FIBRILLATION. DO NOT SELECT "YES" IF YOUR ONLY HEART CONDITION WAS A HEART ATTACK.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD A FORM OF HEART DISEASE  
NO, I HAVE NOT HAD A FORM OF HEART DISEASE



1.1 What kind of heart disease did you have?

HINT TEXT

SELECT ALL THAT APPLY.

MULTI SELECT

OPTIONS: CONGESTIVE HEART FAILURE (THE HEART DOES NOT PUMP BLOOD PROPERLY)  
VALVULAR HEART DISEASE (A HARDENING OF HEART VALVES, RESTRICTING BLOOD FLOW)  
ARRHYTHMIA (AN IRREGULAR HEART RHYTHM)  
CORONARY HEART DISEASE (A PLAQUE BUILDUP IN THE ARTERIES, REDUCING BLOOD FLOW AND NARROWING OF CORONARY ARTERIES)  
ATRIAL FIBRILLATION (AN IRREGULAR, RAPID HEART BEAT)  
OTHER: [TEXT INPUT]

SKIP IF: 1. HAVE YOU EVER HAD A FORM OF HEART DISEASE?

IS: NO, I HAVE NOT HAD A FORM OF HEART DISEASE

1.2

Did you receive treatment for your heart disease condition(s)?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES

NO

SKIP IF: 1. HAVE YOU EVER HAD A FORM OF HEART DISEASE?

IS: NO, I HAVE NOT HAD A FORM OF HEART DISEASE

---

1.3

Did your heart condition(s) limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES

NO

SKIP IF: 1. HAVE YOU EVER HAD A FORM OF HEART DISEASE?

IS: NO, I HAVE NOT HAD A FORM OF HEART DISEASE

---

2

Have you ever had a heart attack?

HINT TEXT

A HEART ATTACK IS A BLOCKAGE OF BLOOD FLOW DUE TO LACK OF BLOOD SUPPLY.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD AT LEAST ONE HEART ATTACK

NO, I HAVE NOT HAD A HEART ATTACK

---

2.1

How many heart attacks have you had?

HINT TEXT

PLEASE ENTER A NUMBER, I.E. 1, 2, 3, ETC.

TEXT INPUT

SKIP IF: 2. HAVE YOU EVER HAD A HEART ATTACK?

IS: NO, I HAVE NOT HAD A HEART ATTACK

---

3

Have you ever had high blood pressure?

HINT TEXT

IF YOUR HIGH BLOOD PRESSURE IS/WAS CONTROLLED WITH MEDICATION OR DIET, SELECT "YES".

**SINGLE SELECT** (PNTA ENABLED)

**OPTIONS:** YES, I HAVE HAD BLOOD PRESSURE  
NO, I HAVE NOT HAD HIGH BLOOD PRESSURE

---

3.1

Did you receive treatment for your high blood pressure?

**HINT TEXT**  
(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 3. HAVE YOU EVER HAD HIGH BLOOD PRESSURE?  
**IS:** NO, I HAVE NOT HAD HIGH BLOOD PRESSURE

---

3.2

Did your high blood pressure limit your activities?

**HINT TEXT**  
(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 3. HAVE YOU EVER HAD HIGH BLOOD PRESSURE?  
**IS:** NO, I HAVE NOT HAD HIGH BLOOD PRESSURE

---

4

Have you ever had lung disease (not cancer)?

**HINT TEXT**

LUNG DISEASE MAY INCLUDE ASTHMA, EMPHYSEMA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD, PNEUMONIA, OR TUBERCULOSIS (TB)).

**SINGLE SELECT** (PNTA ENABLED)

**OPTIONS:** YES, I HAVE HAD A FORM OF LUNG DISEASE  
NO, I HAVE NOT HAD A FORM OF LUNG DISEASE

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4.1

What kind of lung disease did you have?

**HINT TEXT**  
SELECT ALL THAT APPLY.

**MULTI SELECT**

**OPTIONS:** ASTHMA  
EMPHYSEMA  
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)  
PNEUMONIA  
TUBERCULOSIS (TB)  
OTHER: [TEXT INPUT]

**SKIP IF:** 4. HAVE YOU EVER HAD LUNG DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD A FORM OF LUNG DISEASE

---

4.2

Did you receive treatment for your lung disease(s)?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 4. HAVE YOU EVER HAD LUNG DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD A FORM OF LUNG DISEASE

---

4.3

Did your lung disease(s) limit your activities?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 4. HAVE YOU EVER HAD LUNG DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD A FORM OF LUNG DISEASE

---

5

Have you ever had diabetes?

**HINT TEXT**

IF YOUR DIABETES IS/WAS CONTROLLED WITH MEDICATION OR LIFESTYLE CHANGES, SELECT "YES".

**SINGLE SELECT (PNTA ENABLED)**

**OPTIONS:** YES, I HAVE HAD DIABETES  
NO, I HAVE NOT HAD DIABETES

---

5.1

Did you receive treatment for your diabetes?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 5. HAVE YOU EVER HAD DIABETES?

IS: NO, I HAVE NOT HAD DIABETES

5.2

Did your diabetes limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 5. HAVE YOU EVER HAD DIABETES?

IS: NO, I HAVE NOT HAD DIABETES

6

Have you had gastric disturbances (not cancer)?

HINT TEXT

GASTRIC DISTURBANCES MAY INCLUDE ACID REFLUX (GERD), GASTRITIS (IRRITATION OF THE STOMACH LINING), HIATAL HERNIA (ORGAN PUSHES THROUGH AN OPENING IN THE MUSCLE OR TISSUE THAT HOLDS IT IN PLACE), ULCER OR ANOTHER STOMACH DISEASE. DO NOT SELECT "YES" FOR THE OCCASIONAL UPSET STOMACH.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD GASTRIC DISTURBANCES  
NO, I HAVE NOT HAD GASTRIC DISTURBANCES

6.1

What type of gastric disturbances did you have?

HINT TEXT

SELECT ALL THAT APPLY.

MULTI SELECT

OPTIONS: ACID REFLUX (GERD)  
GASTRITIS (IRRITATION OF THE STOMACH LINING)  
HIATAL HERNIA (ORGAN PUSHES THROUGH AN OPENING  
IN THE MUSCLE OR TISSUE THAT HOLDS IT IN PLACE)  
ULCER  
OTHER: [TEXT INPUT]

**SKIP IF:** 6. HAVE YOU HAD GASTRIC DISTURBANCES (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD GASTRIC DISTURBANCES

---

6.2

Did you receive treatment for your gastric disturbances?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 6. HAVE YOU HAD GASTRIC DISTURBANCES (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD GASTRIC DISTURBANCES

---

6.3

Did your gastric disturbances limit your activities?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 6. HAVE YOU HAD GASTRIC DISTURBANCES (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD GASTRIC DISTURBANCES

---

7

Have you ever had kidney disease (not cancer)?

**HINT TEXT**

KIDNEY DISEASE MAY INCLUDE RENAL FAILURE (KIDNEYS LOSE THE ABILITY TO BALANCE FLUIDS AND REMOVE WASTE), CYSTS (FLUID FILLED SACS IN KIDNEYS) OR KIDNEY STONES (A HARD MASS OR DEPOSIT THAT FORMS IN THE KIDNEYS).

**SINGLE SELECT (PNTA ENABLED)**

**OPTIONS:** YES, I HAVE HAD KIDNEY DISEASE  
NO, I HAVE NOT HAD KIDNEY DISEASE

---

7.1

What type of kidney disease did you have?

**HINT TEXT**

SELECT ALL THAT APPLY.

**MULTI SELECT**

**OPTIONS:** RENAL FAILURE (KIDNEYS LOSE THE ABILITY TO BALANCE FLUIDS AND REMOVE WASTE)  
CYSTS (FLUID FILLED SACS IN KIDNEYS)  
KIDNEY STONES (A HARD MASS OR DEPOSIT THAT FORMS IN THE KIDNEYS)  
OTHER: [TEXT INPUT]

**SKIP IF:** 7. HAVE YOU EVER HAD KIDNEY DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD KIDNEY DISEASE

---

7.2

Did you receive treatment for your kidney disease?

**HINT TEXT**  
(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 7. HAVE YOU EVER HAD KIDNEY DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD KIDNEY DISEASE

---

7.3

Did your kidney disease limit your activities?

**HINT TEXT**  
(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 7. HAVE YOU EVER HAD KIDNEY DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD KIDNEY DISEASE

---

8

Have you ever had liver disease (not cancer)?

**HINT TEXT**

LIVER DISEASE MAY INCLUDE CIRRHOSIS (FATTY LIVER, OR SCARRING OF THE LIVER) OR FORM OF HEPATITIS (SUCH AS HEPATITIS A, B, OR C).

**SINGLE SELECT (PNTA ENABLED)**

**OPTIONS:** YES, I HAVE HAD LIVER DISEASE  
NO, I HAVE NOT HAD LIVER DISEASE

---

8.1

What type of liver disease did you have?

HINT TEXT

SELECT ALL THAT APPLY.

MULTI SELECT

OPTIONS: CIRRHOSIS (FATTY LIVER, OR SCARRING OF THE LIVER)  
CHRONIC VIRAL HEPATITIS (HEPATITIS C OR HEP C)  
HEPATITIS A  
HEPATITIS B  
OTHER: [TEXT INPUT]

SKIP IF: 8. HAVE YOU EVER HAD LIVER DISEASE (NOT CANCER)?

IS: NO, I HAVE NOT HAD LIVER DISEASE

---

8.2

Did you receive treatment for your liver disease?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 8. HAVE YOU EVER HAD LIVER DISEASE (NOT CANCER)?

IS: NO, I HAVE NOT HAD LIVER DISEASE

---

8.3

Did your liver disease limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 8. HAVE YOU EVER HAD LIVER DISEASE (NOT CANCER)?

IS: NO, I HAVE NOT HAD LIVER DISEASE

---

9

Have you ever had a blood disease (not cancer)?

HINT TEXT

BLOOD DISEASE MAY INCLUDE ANEMIA (DEFICIENCY IN RED BLOOD CELLS), THALASSEMIA (A HEREDITARY BLOOD DISORDER CHARACTERIZED BY FEWER RED BLOOD CELLS THAN NORMAL) OR SICKLE CELL DISEASE (A HEREDITARY FORM OF ANEMIA THAT ALTERS THE SHAPE OF RED BLOOD CELLS INTO CRESCENT/SICKLE SHAPE).

SINGLE SELECT (PNTA ENABLED)

**OPTIONS:** YES, I HAVE HAD A BLOOD DISEASE  
NO, I HAVE NOT HAD A BLOOD DISEASE

---

9.1

### What blood disease did you have?

**HINT TEXT**

SELECT ALL THAT APPLY.

**MULTI SELECT**

**OPTIONS:** ANEMIA (A CONDITION MARKED BY A DEFICIENCY OF RED BLOOD CELLS OR OF HEMOGLOBIN IN THE BLOOD, RESULTING IN PALLOR AND WEARINESS)

THALASSEMIA (A HEREDITARY BLOOD DISORDER CHARACTERIZED BY FEWER RED BLOOD CELLS THAN NORMAL)

SICKLE CELL DISEASE (A HEREDITARY FORM OF ANEMIA THAT ALTERS THE SHAPE OF RED BLOOD CELLS INTO CRESCENT/SICKLE SHAPE)

OTHER: [TEXT INPUT]

**SKIP IF:** 9. HAVE YOU EVER HAD A BLOOD DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD A BLOOD DISEASE

---

9.2

### Did you receive treatment for your blood disease?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES

NO

**SKIP IF:** 9. HAVE YOU EVER HAD A BLOOD DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD A BLOOD DISEASE

---

9.3

### Did your blood disease limit your activities?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES

NO

**SKIP IF:** 9. HAVE YOU EVER HAD A BLOOD DISEASE (NOT CANCER)?

**IS:** NO, I HAVE NOT HAD A BLOOD DISEASE

---

10

Have you ever had cancer?

HINT TEXT

(EMPTY)

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD HAD CANCER  
NO, I HAVE NOT HAD CANCER

10.1

What type of cancer did you have?

HINT TEXT

SELECT ALL THAT APPLY.

MULTI SELECT

OPTIONS: BLADDER  
BREAST  
COLON  
KIDNEY (RENAL CANER)  
LEUKEMIA  
LIVER (HEPATIC CANCER)  
LUNG  
LYMPHOMA  
MELANOMA  
PROSTATE  
THYROID  
SKIN (NON-MELANOMA)  
UTERINE  
OTHER: [TEXT INPUT]

SKIP IF: 10. HAVE YOU EVER HAD CANCER?

IS: NO, I HAVE NOT HAD CANCER

10.2

Did you receive treatment for your cancer?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 10. HAVE YOU EVER HAD CANCER?

IS: NO, I HAVE NOT HAD CANCER

10.3

Did your cancer limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 10. HAVE YOU EVER HAD CANCER?

IS: NO, I HAVE NOT HAD CANCER

11

Have you had depression?

HINT TEXT

DEPRESSION SYMPTOMS MAY VARY OVER TIME AND INCLUDE BOTHERSOME FEELINGS OF HOPELESSNESS, FEELING “DOWN IN THE DUMPS, LOW, BLUE, OR SAD”. THESE FEELINGS CAN OFTEN BE ACCOMPANIED BY A LOSS OF INTEREST OR ENJOYMENT IN DAILY ACTIVITIES. IF YOU HAVE DEPRESSION AND IT IS TREATED WITH MEDICATION OR NON-MEDICATION- TREATMENT, SUCH AS TALK THERAPY, SELECT “YES”.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD DEPRESSION  
NO, I HAVE NOT HAD DEPRESSION

11.1

Did you receive treatment for your depression?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 11. HAVE YOU HAD DEPRESSION?

IS: NO, I HAVE NOT HAD DEPRESSION

11.2

Did your depression limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 11. HAVE YOU HAD DEPRESSION?

IS: NO, I HAVE NOT HAD DEPRESSION

12

Have you had arthritis?

HINT TEXT

ARTHRITIS MAY INCLUDE OSTEOARTHRITIS/DEGENERATIVE ARTHRITIS OR RHEUMATOID ARTHRITIS.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD ARTHRITIS  
NO, I HAVE NOT HAD ARTHRITIS

12.1

What type of arthritis did you have?

HINT TEXT

SELECT ALL THAT APPLY.

MULTI SELECT

OPTIONS: OSTEOARTHRITIS/DEGENERATIVE ARTHRITIS (TISSUE AT THE END OF THE BONE BEGINS TO WEAR DOWN DUE TO "WEAR AND TEAR")

RHEUMATOID ARTHRITIS (CAUSED BY AN AUTOIMMUNE DISEASE WHERE THE BODY'S IMMUNE SYSTEM ATTACKS THE BODY'S JOINTS)

OTHER: [TEXT INPUT]

SKIP IF: 12. HAVE YOU HAD ARTHRITIS?

IS: NO, I HAVE NOT HAD ARTHRITIS

12.2

Did you receive treatment for your arthritis?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 12. HAVE YOU HAD ARTHRITIS?

IS: NO, I HAVE NOT HAD ARTHRITIS

12.3

Did your arthritis limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

**SKIP IF:** 12. HAVE YOU HAD ARTHRITIS?

**IS:** NO, I HAVE NOT HAD ARTHRITIS

---

13

Have you had back pain lasting longer than a week?

**HINT TEXT**

DO NOT SELECT "YES" IF THE ONLY BACK PAIN YOU HAVE EXPERIENCED HAS BEEN ASSOCIATED WITH A SPECIFIC INJURY OR TRAUMA SUCH A PULL, STRAIN, SPRAIN, OR OVEREXERTION.

**SINGLE SELECT** (PNTA ENABLED)

**OPTIONS:** YES, I HAVE HAD BACK PAIN  
NO, I HAVE NOT HAD BACK PAIN

---

13.1

Did you receive treatment for your back pain?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 13. HAVE YOU HAD BACK PAIN LASTING LONGER THAN A WEEK?

**IS:** NO, I HAVE NOT HAD BACK PAIN

---

13.2

Did your back pain limit your activities?

**HINT TEXT**

(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 13. HAVE YOU HAD BACK PAIN LASTING LONGER THAN A WEEK?

**IS:** NO, I HAVE NOT HAD BACK PAIN

---

14

Have you had anxiety?

**HINT TEXT**

ANXIETY IS CHARACTERIZED BY NOTICEABLE FEELINGS OF WORRY OR FEAR THAT CAN INTERFERE WITH DAILY ACTIVITIES. THESE SYMPTOMS MAY BE CONSTANT, OR THEY MAY COME AND GO, BUT HAVE A CLEAR IMPACT ON FUNCTIONING. IF YOU HAVE ANXIETY AND IT IS MANAGED WITH MEDICATION, SELECT "YES".

**SINGLE SELECT** (PNTA ENABLED)

**OPTIONS:** YES, I HAVE HAD ANXIETY  
NO, I HAVE NOT HAD ANXIETY

---

14.1

Did you receive treatment for your anxiety?

**HINT TEXT**  
(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 14. HAVE YOU HAD ANXIETY?  
**IS:** NO, I HAVE NOT HAD ANXIETY

---

14.2

Did your anxiety limit your activities?

**HINT TEXT**  
(EMPTY)

**SINGLE SELECT**

**OPTIONS:** YES  
NO

**SKIP IF:** 14. HAVE YOU HAD ANXIETY?  
**IS:** NO, I HAVE NOT HAD ANXIETY

---

15

Have you ever had a stroke (including TIA or transient ischemic attack)?

**HINT TEXT**

A STROKE IS AN INTERRUPTION IN BLOOD SUPPLY TO THE BRAIN.

**SINGLE SELECT** (PNTA ENABLED)

**OPTIONS:** YES, I HAVE HAD A STROKE  
NO, I HAVE NOT HAD A STROKE

---

15.1

How many strokes have you had?

**HINT TEXT**

PLEASE ENTER A NUMBER, I.E. 1, 2, 3, ETC.

**TEXT INPUT**

**SKIP IF:** 15. HAVE YOU EVER HAD A STROKE (INCLUDING TIA OR TRANSIENT ISCHEMIC ATTACK)?  
**IS:** NO, I HAVE NOT HAD A STROKE

15.2

Did your stroke(s) limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES

NO

**SKIP IF:** 15. HAVE YOU EVER HAD A STROKE (INCLUDING TIA OR TRANSIENT ISCHEMIC ATTACK)?**IS:** NO, I HAVE NOT HAD A STROKE

16

Have you had a traumatic brain injury (TBI)?

HINT TEXT

A TRAUMATIC BRAIN INJURY IS A DISRUPTION TO NORMAL BRAIN FUNCTION CAUSED BY A BLOW, JOLT, OR OTHER HEAD INJURY.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD A TRAUMATIC BRAIN INJURY

NO, I HAVE NOT HAD A TRAUMATIC BRAIN INJURY

16.1

How many TBI's have you had?

HINT TEXT

PLEASE ENTER A NUMBER, I.E. 1, 2, 3, ETC.

TEXT INPUT

**SKIP IF:** 16. HAVE YOU HAD A TRAUMATIC BRAIN INJURY (TBI)?**IS:** NO, I HAVE NOT HAD A TRAUMATIC BRAIN INJURY

16.2

Did you lose consciousness (for more than 10 minutes) during any TBI?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES

NO

**SKIP IF:** 16. HAVE YOU HAD A TRAUMATIC BRAIN INJURY (TBI)?**IS:** NO, I HAVE NOT HAD A TRAUMATIC BRAIN INJURY

16.3

Did any of your TBI's limit your activities?

HINT TEXT

(EMPTY)

SINGLE SELECT

OPTIONS: YES  
NO

SKIP IF: 16. HAVE YOU HAD A TRAUMATIC BRAIN INJURY (TBI)?

IS: NO, I HAVE NOT HAD A TRAUMATIC BRAIN INJURY

17

Have you had any surgeries that required anesthesia?

HINT TEXT

ANESTHESIA CAN INCLUDE MEDICALLY INDUCED, TEMPORARY STATE OF LOSS OF SENSATION OR AWARENESS.

SINGLE SELECT (PNTA ENABLED)

OPTIONS: YES, I HAVE HAD SURGERY UNDER ANESTHESIA  
NO, I HAVE NOT HAD SURGERY UNDER ANESTHESIA

17.1

Which type(s) of surgery have you had?

HINT TEXT

SELECT ALL THAT APPLY.

MULTI SELECT

OPTIONS: CARDIAC SURGERY (SUCH AS PACEMAKER OR CARDIAC DEVICE IMPLANTATION, CORONARY ARTERY BYPASS SURGERY, HEART VALVE REPAIR OR REPLACEMENT, ANEURYSM REPAIR, OPEN HEART SURGERY, OR HEART TRANSPLANT)

ORTHOPAEDIC SURGERY (INVOLVING THE MUSCULOSKELETAL SYSTEM, SUCH AS ARTHROSCOPIC JOINT SURGERY; BONE FRACTURE REPAIR; HIP REPLACEMENT; OR HAND, ELBOW, SHOULDER, ARM, FOOT, ANKLE, OR SPINE SURGERIES)

GASTROINTESTINAL SURGERY (SUCH AS APPENDECTOMY, ADRENALECTOMY, SPLENECTOMY, GALL STONE SURGERY, COLON SURGERY, PANCREATIC SURGERY, POLYP/PEPTIC ULCER SURGERY, OR SURGICAL REDUCTION OF THE STOMACH)

CRANIAL OR BRAIN SURGERY (SUCH AS DEEP BRAIN STIMULATION, BRAIN ANEURYSM, BRAIN ABSCESSSES, OR SURGERY TO RELIEVE PRESSURE AFTER BRAIN INJURY)

TUMOR REMOVAL (REMOVAL OF ABNORMAL GROWTH OF CELLS, SUCH AS ADENOMAS, FIBROMAS OR FIBROIDS; HEMANGIOMAS, OR BUILD UP OF BLOOD CELLS UNDER THE SKIN OR INTERNAL ORGANS; MENINGIOMAS, OR TUMORS DEVELOPING AROUND BRAIN OR SPINE; MYOMAS, OR TUMORS DEVELOPING IN THE MUSCLES OF THE STOMACH; OR LIPOMAS FROM FAT CELLS)

PULMONARY (LUNG) SURGERY (SUCH AS LOBECTOMY, OR REMOVAL OF LUNG LOBE/S; WEDGE RESECTION, OR REMOVAL OF CANCEROUS SECTION OF LUNG; OR SLEEVE RESECTION, WHICH IS THE REMOVAL OF THE BRONCHUS)

ENT SURGERY (ANY SURGERY INVOLVING THE EAR, NOSE OR THROAT )

EYE SURGERY (SUCH AS GLAUCOMA SURGERY; CATARACT SURGERY; LASER VISION CORRECTION, SUCH AS LASIK ® SURGERY; OR CANALOPLASTY TO IMPROVE THE EYE'S DRAINAGE SYSTEM BY WIDENING THE TEAR CANAL TO REDUCE EYE PRESSURE)

REPRODUCTIVE SURGERY (SUCH AS FALLOPIAN TUBE OBSTRUCTION, VASECTOMY)

COSMETIC SURGERY (SUCH AS FACIAL CONTOURING, RHINOPLASTY, LIPOSUCTION, COSMETIC IMPLANTS)

OTHER: [TEXT INPUT]

**SKIP IF:** 17. HAVE YOU HAD ANY SURGERIES THAT REQUIRED ANESTHESIA?

**IS:** NO, I HAVE NOT HAD SURGERY UNDER ANESTHESIA

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