16. Date and type of operation or treatment performed. For surgery, please state surgical table and code. If no surgery was performed, please state treatment and medication given.		
17. Where 2 or more surgical procedures were performed, please specify whether they were done through the same incision.		
18. When was the patient <u>first</u> advised to have the surgery? Name and address of the doctor who advised the patient to have the surgery.		
19. Was the treatment medically necessary? If 'No', please give details.	☐ Yes	☐ No
20. Was the hospitalisation/surgery for the following treatment items, procedures, conditions, activities or their related complications?		
a) Health screening related examinations, admission for diagnostic purpose, genetic screening, treatment of a preventive nature, cosmetic treatment, surgery/treatment for obesity, correction of eye refraction, squint or other eye misalignment? If 'Yes', please give details.	☐ Yes	☐ No
b) Birth defects, congenital abnormalities, or developmental delay/learning disabilities in children? If 'Yes', please give details.	☐ Yes	☐ No
c) Psychological disorder, personality disorder, behavioural disorder, emotional or mental conditions or illness/injury resulting from such disorders? If 'Yes', please give details.	☐ Yes	☐ No
d) Elective abortion, pregnancy or complication arising from pregnancy, complications arising during or after childbirth? If 'Yes', please give details.	☐ Yes	☐ No
e) Infertility, sub-fertility, assisted conception, erectile dysfunction, impotence or contraceptive treatment? If 'Yes', please give details.	☐ Yes	☐ No
f) Venereal diseases, AIDS, AIDS related complex or infection by Human Immunodeficiency Virus (HIV)? If 'Yes', please give details.	☐ Yes	☐ No
g) Intentional, self-inflicted injuries or injuries resulting from attempted suicide? If 'Yes', please give details.	☐ Yes	☐ No
h) Drug addiction or alcoholism or illness/injury resulting from or under the influence of alcohol or drugs? If 'Yes', please give details.	☐ Yes	☐ No
i) Dental treatment, oral surgery, orthodontics, orthognathic surgery, oral and maxillofacial surgery or temporo-mandibular joint disorder? If 'Yes', please give details.	☐ Yes	☐ No
j) An accident? If 'Yes', please give details of the accident and whether it is work-related and whether police report was made.	☐ Yes	☐ No
21. Has patient fully recovered from the condition(s)? If 'No', what are the follow-up treatments required?		

Name and stamp of attending doctor	Signature of attending doctor
Date (dd/mm/yyyy)	Hospital or clinic's name and address