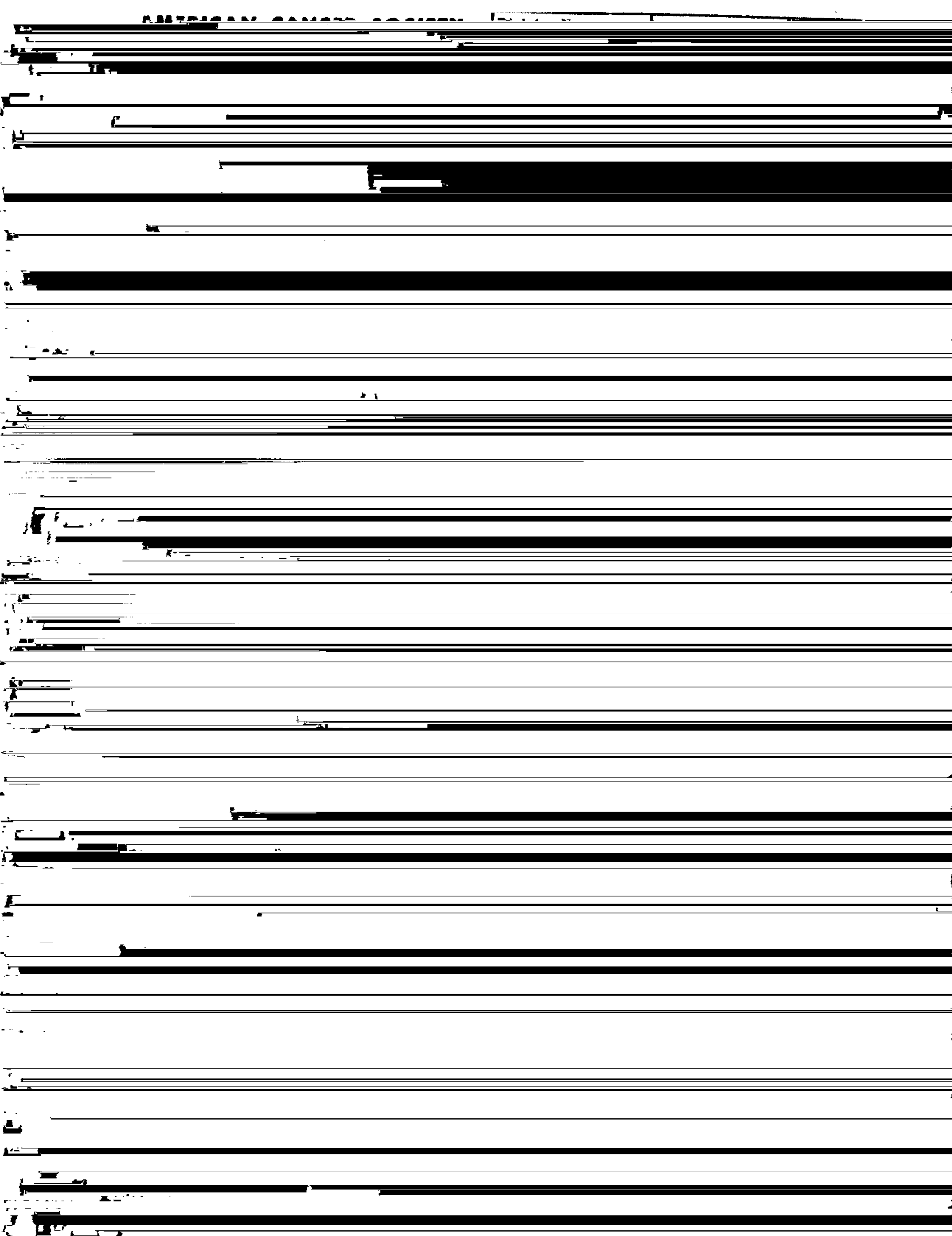

4. Have you ever had a surgical operation? Yes ☐ No ☐ Summary-129

If "yes," please specify type of operation(s): 130 - 133

5. Have you ever had an X-ray or fluoroscopic examination of your stomach or abdomen? 136 Yes ☐ No ☐

6. Have you ever been treated with radium, X-rays, or radioactive isotopes? 137 Yes ☐ No ☐

If "yes," what part of your body?

What disease were you treated for?

PRESENT PHYSICAL COMPLAINTS: Please check "yes" or "no" after each complaint listed. If you check "yes," please indicate the severity of the condition.

1. Cough: 138 Yes ☐ No ☐ | 10. Blood in the Stool: 144 Yes ☐ No ☐ | 19. Headaches: 147 Yes ☐ No ☐

162-176, 178 Blank for males

HABITS:

MISCELLANEOUS:

226 1. What is your present occupation?

227 If retired, what was your previous occupation?