

Tonsillectomy & Adenoidectomy Form

Date form completed:

_____ (m-d-y)

1. Tonsillectomy

- Yes
- No

2. Tonsillectomy date

_____ (m-d-y)

3. Adenoidectomy?

- Yes
- No

4. Adenoidectomy date?

_____ (m-d-y)

5. Indications (check all that apply)

- sleep disordered breathing
- recurrent infection
- hypertrophy
- recurrent tonsillitis
- halitosis
- other
- not available

6. Indications Other
