

Doctor's Building 1 20375 W 151st Street, Suite 463 Olathe, KS 66061 913-782-8577

Fax: 913-782-2616

Office Hours: Monday – Friday: 8 am – 5 pm

Welcome to our practice. Thank you for choosing the physicians at Midwest Surgical Associates for your surgical needs. In order to expedite your first visit, <u>please arrive 20 minutes prior to your appointment time</u> with your <u>paperwork completed</u>. A photo ID and current insurance card will be requested, as well as any applicable insurance co-payment. If you need assistance completing our forms, please call our office at 913-782-8577 and we will be happy to assist you.

For your convenience, you may fax completed forms to Midwest Surgical Associates at the following secured fax number: 913-782-2616. Please fax forms at least two (2) business days prior to your appointment. If you opt to fax your forms, you may arrive 10 minutes prior to your appointment time.

	Today's Date:			
	State: Zip:			
Cell Phone:	Work Phone:			
	Primary care physician:			
	Sex: M F			
Married	Divorced Widowed			
	Relationship			
Work Phone:				
	Cell Phone: Married			

OHP 669 Revised 12/12/16; cd

Patient name:				Date:					
Patient Medical His	tory – Pl	lease ch	eck all	that apply t	o your me	edical history			
Anemia	•			11.		Diabetes			
Anxiety					Diverticulosis/Diverticulitis				
Arthritis/Gout	out					Gallstones			
Asthma						GERD			
Back/Joint Prob						Hiatal Hernia			
Breast Cancer						High Blood Pressure			
Chronic Renal F	hronic Renal Failure					High Cholesterol			
	Cirrhosis						Pancreatitis		
	Colon/Bowel Problems						Peptic Ulcer		
	Colon Cancer						Prostate Enlargement/Cancer		
	COPD						Seizures		
	Coronary Artery Disease					Strokes/TIA			
	Crohn's/Ulcerative Colitis						Thyroid Disease		
Depression									
Surgical History – P	lease che	ck all t	hat appl	y to your si	ırgical pa	st			
	Appendectomy						Orthopedic (knee/hip)		
	Breast Lump/Mastectomy					Pacemaker			
	Gallbladder Removal					Prostate			
Hernia					Thyroid				
Heart Bypass					Tonsillectomy				
Hysterectomy						Other			
Laparoscopy									
Family History – Ple	ease checl	k all tha	at apply	to your fan	nily medic	cal history			
Breast Cancer			M	other	Sister				
Colon Polyps/C	olon Car	ncer	M	other	Father	Brother	Sister		
Coronary Artery	Disease)	M	other	Father	Brother	Sister		
Diabetes			Mother		Father	Brother	Sister		
Gastric Cancer			Mother		Father	Brother	Sister		
Liver Disease			Mother		Father	Brother	Sister		
Pancreatic Canc	Pancreatic Cancer			other	Father	Brother	Sister		
Ulceratrive Coli	tis/Croh	ns	M	other	Father	Brother	Sister		
Social History – Plea	se circle								
Smoking/Tobacco Use	Quit	No	Yes	Packs pe	r day Number of years				
Alcohol Use:	Quit	No	Yes						
			If ves	what type:	beer lin	uor wine how r	many drinks per day?		
Coffaina Usa	Numbo	of our	•		_		inally drilling per duy		
	affeine Use Number of cups/drinks a day?								
Exercise:	No	Yes	How	frequently	:				
Preventative Screen	0	lease cl	neck all	that apply		7			
Colonoscopy (>	_						y (women age 40-74)		
Date:				_		Date:			
Any Other Tests	;								

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Patient name:_	Date:
Please indica	te if you are CURRENTLY having any of the symptoms listed below. By not selecting a symptom you are denying having this problem at this time.
Constitutional	☐ Decrease in appetite ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight loss ☐ Weight gair
Eyes/ENT	☐ Blurred or double vision ☐ Diminished Vision ☐ Drainage ☐ Hoarseness ☐ Hearing loss or ringing ☐ Chronic sinus problems ☐ Nose bleeds
Respiratory	\square Chronic Cough \square Wheezing \square Shortness of breath
Endocrine	☐ Increased thirst ☐ Cold/Heat intolerance ☐ Breast Discharge ☐ Change in menstrual cycle
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ Pacemaker
Hematology	☐ Coumadin treatment ☐ Nose Bleeds ☐ Easy bruising ☐ Swollen glands ☐ Anemia
GI	□ Abdominal Pain □ Nausea □ Vomiting □ Heartburn □ Appetite Loss □ Bloody Stool □ Diarrhea □ Constipation □ Rectal Pain
Genitourinary	☐ Frequent urination ☐ Burning/painful urination ☐ Blood in urine ☐ Decreased flow
Musculoskeletal	☐ Painful joints ☐ Joint swelling ☐ Muscle cramps ☐ Back pain
Skin	☐ Itching ☐ Rash ☐ Hives ☐ Skin Cancer ☐ Dry Skin
Neurological	□ Dizzy or light headed□ Epilepsy□ Numbness or tingling□ Memory loss□ Difficulty speaking
Medications: Li	ist all medications you presently take. (include dosage and how often)
Pharmacy Namo	Pharmacy Address: Pharmacy Phone: Mail Order:
Non-Traditional	I Medications Please list herbs and/or dietary supplements
Allergies: Dru	ug/Agent Reaction

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