United Surgical Associates
Of Kansas City
Patient History

Demographics: Please fill out completely

Name First: _____ Last: _____ MI: _____
Date of Birth_____ Gender: **Male** **Female** SSN: _____
(Please Circle) Married Single Employed Unemployed Disabled Student
Ethnicity (Please Circle) Caucasian African American Arabic Hispanic Asian

Address Information:
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Home: _____ Cell:_____ Is it ok to leave a message on your home phone? Y N On your cell phone? Y N
E-Mail Address _____

Employment Information:
Employer**: _____** Occupation: **_____**
Work #: **_____**

Insurance Information:
Insurance Company: **_____**Policy #: **_____**
Group #:_____ Policy Holder Full Name:_____
Policy Holder DOB: _____ Policy Holder SSN: _____
Relationship to Insured:_____ Insured Employer:_____

Referring Physician: **_____** **Primary Care** Physician _____
How did you hear about us? Friend Internet Other family member

Social History: (please circle) Tobacco Use Y N Alcohol Y N Substance abuse Y N
Emergency Contact: _____

Past Medical History: ***Please list (for example: High blood pressure)***
_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family History: *Please indicate relationship*

Heart Disease	_____	High Blood Pressure	_____
Sleep Apnea	_____	Diabetes Mellitus	_____
GERD	_____	Depression	_____
Obesity	_____	Mental Illness	_____
Bleeding Disorders	_____	Cancer	_____

Surgical/Hospitalization History: *Please list any/all surgeries or hospitalizations you have had.*

_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____

Current Medications: *Please List*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug/Medication Allergies: *Please list and type of reaction*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list skin allergies if any

_____ _____ _____
_____ _____ _____
_____ _____ _____