WICHITA SURGICAL SPECIALISTS, P.A.

NEW PATIENT INFORMATION QUESTIONNAIRE

Please fill out as much as possible

Name _____ Age _____ Today's Date ____/____/____

Problem you are having: _____

When did it begin? _____

What treatment(s) have you had? _____

_____

What doctors have you seen? _____

Past or current illnesses: _____

Other family or friends seen by Dr. Moufarrij? _____

3-23-95