Drossman Gastroenterology, PLLC

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PATIENT INFORMATION

DATE: ____________________

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME: ____________________

PRIMARY PHONE: ____________________ ☐ home ☐ cell ☐ work

ALTERNATE PHONE: ____________________ ☐ home ☐ cell ☐ work

STREET ADDRESS: ____________________

CITY, STATE, ZIP ____________________

SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: ____________________

EMAIL ADDRESS: ____________________

What GI Symptoms are you experiencing today? Check all that apply:

- ☐ Atypical Chest Pain
- ☐ Functional Dyspepsia
- ☐ Dysphagia
- ☐ Reflux
- ☐ Swallowing Disorder
- ☐ Cyclic Vomiting
- ☐ Vomiting
- ☐ Nausea
- ☐ Crohn's Disease
- ☐ IBD
- ☐ Ulcerative Colitis
- ☐ Pelvic Pain
- ☐ Rectal Pain
- ☐ Chronic Abdominal Pain
- ☐ IBS-Diarrhea
- ☐ IBS- Constipation
- ☐ IBS- Mixed
- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ Pelvic Floor Dysfunction
- ☐ Fecal Incontinence
- ☐ GI Malignancies
- ☐ Motility Problem
- ☐ Currently on narcotic medication
- ☐ Other Functional GI Disorders
- ☐ Other: ____________________

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SPECIFIC QUESTION(S) TO BE ADDRESSED: ____________________

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Please mark any other conditions you have had or currently experience:

Please mark "P" for Past and "C" for current:	Condition:	Please mark "P" for Past and "C" for current:	Condition:
	Allergies		Hernia
	Aneurysm		High BP
	Angina		High cholesterol
	Arthritis		Joint injuries
	Asthma		Kidney disease
	Cancer		Obesity
	Depression/anxiety		Osteoporosis
	Diabetes		Pacemaker
	Disc problems		Phlebitis (clots)
	Emphysema		Seizures
	Fractures		Stroke
	Heart surgery		Ulcer
	Hepatitis		Varicose

Family History: Place a check under applicable family member(s)

Condition:	Parent	Grandparent	Sibling	Children
Alzheimer's				
Cancer (type?)				
Diabetes				
Heart attack (age?)				
High blood pressure				

Please list all medications below, including supplements:

Medication:	Dose:	Medication:	Dose:
1		9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8		16	

Are the following up to date? Please give date of your last:

Pap smear: _________ Normal or abnormal?
Mammogram: _________ Normal or abnormal?
Bone density: _________ Normal or abnormal?
Colonoscopy: _________ Normal or abnormal?

What do you do for exercise? ____

Please list any medication/food allergies: _____________________________________

Do you smoke? ________ # Packs per day ______ If former smoker, date quit: _____________

Do you drink alcohol? ___________ If yes, how much and how often: _______________

Anything else you would like the physician to know for your appointment today?

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If this is your first visit with Dr Drossman, please let us know how you heard about our practice.

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Please be aware that Dr. Drossman periodically hosts professional visitors who choose to spend time with him in clinic I order to improve their clinical skills. Usually they will only observe the clinical visit. When a health professional is visiting the center, you will be asked just prior to seeing Dr. Drossman if you would agree to have this person be present during the visit. While we would appreciate you allowing them to enhance their learning experience with you, you are not obligated to agree to this. Your decision will not affect the care you receive from Dr. Drossman and his team.