

**GASTROENTEROLOGY NEW PATIENT INFORMATION – Dr. Grossman**

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Insurance: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

Please check any of the following disorders that apply to you:

- |                            |                           |                            |
|----------------------------|---------------------------|----------------------------|
| Hiatal hernia _____        | Pancreatitis _____        | Arthritis _____            |
| Reflux/ Heartburn _____    | Cirrhosis _____           | Thyroid disease _____      |
| Esophageal stricture _____ | Hepatitis _____           | Diabetes _____             |
| Ulcers _____               | Lung disease _____        | Anemia _____               |
| Irritable bowel _____      | Heart disease _____       | Circulation disorder _____ |
| Diverticulosis _____       | High cholesterol _____    | Stroke _____               |
| Colitis _____              | High blood pressure _____ | Seizures _____             |
| Colon polyps _____         | Kidney disease _____      | Depression _____           |
| Hemorrhoids _____          | Bladder problems _____    | Cataracts _____            |
| Gallstones _____           | Prostate disease _____    | Glaucoma _____             |

Cancer: Please specify: \_\_\_\_\_

Other: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Please list any prescription medications, vitamins, herbal supplements and over-the-counter medications such as Tylenol, Aspirin, etc. that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies to medications: \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ Do you drink alcohol, if so, how much? \_\_\_\_\_

Do you drink caffeinated beverages? \_\_\_\_\_

| <b>Family history:</b> | <b>Age or Age deceased</b> | <b>Health problems</b> |
|------------------------|----------------------------|------------------------|
| Father:                | _____                      | _____                  |
| Mother:                | _____                      | _____                  |
| Brothers:              | _____                      | _____                  |
| Sisters:               | _____                      | _____                  |

To the best of my knowledge the statements above are accurate and complete.

Patient signature: \_\_\_\_\_