Office Use Only
W: ________________
H: ________________
BP: _______ / _______
P: __________________
Temp: _____________°F

Digestive Disease Physicians & GI Endoscopy of Northern VA, LLC
4660 Kenmore Avenue, Ste. #100, Alexandria, VA 22304
Telephone: (703)751-5763 | Fax: (703) 370-8704
www.digestivediseasephysicians.com

Follow up Appointment

First name ________________________ Last name ___________________________________

Date of Birth_____________________ Best Contact # _________________________________

Referring Physician ____
Primary Care Physician (only if different from above) __________________________________
Any additional Physicians/Providers you would like notes/procedure reports sent to:
____

What is the purpose of your visit today?
____

Have you recently had any lab work, ultrasound, or CT scan?
Yes – **If, yes, what, when, and where?** No
____

List *if any new* medical conditions and surgeries?:
_______________________ ________________________ ____________________________
_______________________ ________________________ ____________________________
_______________________ ________________________ ____________________________

List Pharmacy name, address and phone number **(BE SPECFIC)**
____

Drug Allergies: ____

List *ALL* medications: (include prescription, over the counter, herbals, supplements), dose and number of times taken per day)
_______________________ ________________________ ____________________________
_______________________ ________________________ ____________________________
_______________________ ________________________ ____________________________
Aspirin 81mg 325mg None

Social History:
Occupation____

Marital Status ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻ Same Sex Partner

Tobacco use ◻ Yes – How much? ______________ ◻ No ◻ Former Smoker

Alcohol use ◻ Yes – How much? ______________ ◻ No

Drug use ◻ Yes – How much? ______________ ◻ No

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