Jersey Medical Weight Loss

1527 Route 27 – Suite 2100, Somerset, NJ 08873
(732) 659-6650 – Office (732) 659-6649 – Fax

Name :______________________________________ **Date of Birth**: ____/____/_______ **Martial Status**: S M D W **Gender:** M F

List all medications to include over the counter, vitamins, herbs, etc. along with dosage and how many times per day or week you take it and the reason this medication was prescribed for you. (Ex.: Aspirin 81 mg once a day for heart disease). Use reverse side if needed.

	Name of Medication and Strength	How Many Times	Reason For Taking Medication
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

IMMUNIZATIONS HISTORY

Please place an **X** by each immunization given to you and the date – Thank you.

( ) FLU ____ ( ) Hepatitis B _____ ( )Pneumovax _____ ( )Tetanus _____ ( )Hepatitis A______ ( )Other __________

ALLERGIES

Please let us know if you have any allergies to food, medication(s), x-ray dyes, or any other substance(s). Also, tell us the allergy reaction you experience. ____

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HOSPITALIZATION/SURGERY/PAST MEDICAL HISTORY

Please tell us in detail of any past medical condition(s) you received treatment, were hospitalized or had surgery. Make sure to include the date(s).

Medical Treatments / Surgery / Hospitalization	Date(s)

FAMILY HEALTH HISTORY

Please place an **X** for the family member(s) diagnosed with the following medical condition and at what age were they diagnosed.

Medical Condition	Mother	Father	Brother(s)	Sister(s)	Grandparent(s)	Aunt/Uncle
Bleeding Disease						
Cancer						
Cancer Type						
Diabetes						
Drug and/or Alcohol						
Glaucoma						
Heart Disease						
Hypertension (High Blood Pressure)						
Mental Disease (Depression/Anxiety)						
Stroke						
Other						

PREVENTIVE HEALTH

Please place an **X** by the test or exam you had done and tell us the date it was completed - Thank You.

	Test	Date		Test	Date		Test	Date
	Breast Exam			Colonoscopy			Eye Exam	
	Mammogram			Prostate Exam			Stool Check for Blood	
	Pap Smear			Cholesterol Check			Sigmoidoscopy	

REVIEW OF SYMPTOMS

Please **Circle** your answer to the questions listed below:

1. DO YOU HAVE HEADACHES?	**Y N**	7. DO YOU SUFFER FROM SEXUAL DYSFUNCTION?	**Y N**
2. DO YOU HAVE DIFFICULTY HEARING?	**Y N**	8. DO YOU HAVE DIFFICULTY BREATHING?	**Y N**
3. DO YOU HAVE TROUBLE SWALLOWING?	**Y N**	9. DO YOU HAVE FREQUENT CHEST PAIN?	**Y N**
4. HAVE YOU HAD ANY UNINTENTIONAL WEIGHT LOSS?	**Y N**	10. DO YOU HAVE FREQUENT DIARRHEA?	**Y N**
5. DO YOU SUFFER FROM FREQUENT ABDOMINAL PAIN?	**Y N**	11. ARE YOU FREQUENTLY CONSTIPATED?	**Y N**
6. ARE YOU HAVING TROUBLE WALKING?	**Y N**	12. DO YOU HAVE FREQUENT BACK PAIN?	**Y N**

PLEASE ELABORATE ON ANY OF THE ABOVE ANSWERS:

PHYSICIAN: Aparna Chandrasekaran **Signature**:______________________________ **Date:** ____________