Jersey Medical Weight Loss
1527 Route 27 - Suite 2100,Somerset ,NJ 08873
(732) 659-6650- Office / (732) 659-6649- Fax

# MEDICAL VISIT QUESTIONNAIRE

Name:_____ Date of Birth :___/___/___ Gender : M / F

## MEDICATIONS

List all medications to include over the counter , vitamins, herb, 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 ).

| **Name of Medication and Strength** | **How Many Times** | **Reason For taking Medication** |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

## HOSPITALIZATION/ SURGERY / PAST MEDICAL HISTORY

| MEDICAL TREATMENTS/ SURGERY/ HOSPITALIZATION | DATE (s) |
|---|---|
| | |
| | |
| | |
| | |
| | |

## 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 experienced.

_____

_____

## FAMILY HEALTH HISTORY

| Medical Conditon | Yes | NO | Relatives |
|---|---|---|---|
| Cancer | | | |
| Diabetes | | | |
| Heart Disease / Stroke | | | |
| Hypertension ( High Blood Pressure | | | |
| Mental Disease (Depression/ Anxiety) | | | |
| Other | | | |

## 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 HAD ANY UNINTENTIONAL WEIGHT LOSS? | Y N | 10.DO YOU HAVE FREQUENT DIARRHEA? | Y N |
| 5.DO YOU SUFFER FROM FREUENT ABDOMINAL PAIN ? | Y N | 11.ARE YOU FREQENTLY CONSTIPATED? | Y N |
| 6.ARE YOU HAVING TROUBLE WALKING ? | Y N | 12.DO YOU HAVE FREQUENT BACK PAIN? | Y N |

NAME :_____ SIGNATURE :_____ DATE _____