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

WEIGHT LOSS VISIT QUESTIONNAIRE

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

MEDICATIONS

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

Name of Medication and Strength	How many Times	Reason for taking Medications
1.		
2.		
3.		
4.		
5.		

ALLERGIES

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FOOD	Y N	LATEX	Y N
MEDICATIONS	Y N	OTHERS	Y N

If yes give details

_____

PAST MEDICAL HISTORY

DO YOU HAVE :

1.Diabetes	Y N	6.Heart murmur	Y N
2.Hypertension	Y N	7.Anemia	Y N
3.High Cholesterol	Y N	8.Pacemaker	Y N
4.Sleep apnea	Y N	9.Any metal Implants	Y N
5.Arthritis	Y N	10. Cancer	Y N

FAMILY HEALTH HISTORY

Medical Conditon	Yes	NO	Relatives
Cancer			
Diabetes			
Heart Disease / Stroke			
Hypertension			
Mental Disease			
Other			

LIFESTYLE INFORMATION QUESTIONS

1.If I have my favorite foods in the house, I feel the food is calling me to have some in between meals

Never/ Rarely Sometimes Often Almost Always

2. I snore loudly or I am very tired during waking hours or both

Never/ Rarely Sometimes Often Almost Always

3.In past during dieting, I have lost the willpower to stay on track and reach my goals

Never/ Rarely Sometimes Often Almost Always

4. Each week I spend the following amount of time exercising

No Time Less Than 2 Hour 2-4 Hour More than 4 Hour

5. I have poor eating habits, including fast eating, overeating, mindless snacking and poor food choices

Never/ Rarely Sometimes Often Almost Always

6.I have great difficulty resisting food temptations at social occasions and recreatonal settings

Never/ Rarely Sometimes Often Almost Always

7.In a typical week, how many meals do you eat at fast food resturants?

0-1 2-3 4-5 More than 5

8. I feel that I have a high level of stress in my life

Never/ Rarely Sometimes Often Almost Always

9. I tend to reach for food when I am happy, bored, sad, or stressed

Strongly Disagree Disagree Agree Strongly Agree

HOW MANY TIMES PER WEEK DO YOU EAT FROM ONE OF THESE LOCATIONS ?

MEAL TYPE	PREPARE AT HOME	ON -THE - GO	FAST FOOD
BREAKFAST			
LUNCH			
SNACKS			
DINNER			
TOTAL			

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 FEEL DEPRESSED ?	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.DO YOU HAVE ANY PAIN?	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 :_____