



**New Image Medical Center**  
**103 Parker Road, Suite B**  
**West Long Branch, NJ 07764**  
**732-923-1777**  
**fax: 732-923-1772**

**REGISTRATION: PLEASE PRINT – EVERYTHING MUST BE FILLED OUT**

**PATIENT INFORMATION**

Patient: \_\_\_\_\_  
FIRST Name LAST Name Initial

Social Security Number: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Sex  F  M

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

How do you prefer to be contacted:  Home Phone  Cell Phone  E-mail  Work Phone

Is it alright to leave message on the phone:  YES  NO

Relation to Insured (circle): Self Spouse Child Parent Grandparent

Marital Status: Single Married Divorced Widowed

**GUARANTOR DETAILS ( Skip section if you are the guarantor)**

Relation to Patient (circle): Spouse Child Parent Grandparent

Name: \_\_\_\_\_  
Last Name First Name Initial

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**REFERRING PHYSICIAN ( if applicable)**

Name: \_\_\_\_\_  
Last Name First Name

Specialty: \_\_\_\_\_

**EMERGENCY CONTACT**

Relation to Patient (circle): Spouse Child Parent Grandparent

Name: \_\_\_\_\_  
Last Name First Name Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Company: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Company: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

\_\_\_\_\_  
Name of Insurance Company (ies)

I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize New Image Medical Center to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

I understand that it is ultimately my responsibility to know my coverage benefits.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

YOU WILL NOT BE SEEN UNLESS YOU SIGN THIS FORM.  
IF YOU CHOOSE NOT TO SIGN THIS FORM YOU WILL BE SEEN ONLY IF PAYMENT IS RECEIVED IN FULL AT TIME OF VISIT.

**PRINT YOUR NAME:** \_\_\_\_\_

*Please answer this questionnaire to the best of your ability. All the information is strictly confidential and is only to be used to provide you with the best care possible.*

**MEDICAL HISTORY:**

*Check off all that have ever applied to you*

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Indigestion/GERD/reflux                               |
| <input type="checkbox"/> High cholesterol                        | <input type="checkbox"/> Ulcer disease   |
| <input type="checkbox"/> Diabetes / high sugar                   | <input type="checkbox"/> Hiatal hernia   |
| <input type="checkbox"/> Heart attack                            | <input type="checkbox"/> Irritable bowel syndrome                              |
| <input type="checkbox"/> Heart failure/ congestive heart failure | <input type="checkbox"/> Lactose intolerance                                   |
| <input type="checkbox"/> Arrhythmia/ irregular heart rate        | <input type="checkbox"/> Crohn's/Ulcerative colitis/inflammatory bowel disease |
| <input type="checkbox"/> Mitral valve prolapse                   | <input type="checkbox"/> Sprue/Celiac disease                                  |
| <input type="checkbox"/> Heart murmur                            | <input type="checkbox"/> Diverticulosis  |
| <input type="checkbox"/> Pacemaker                               | <input type="checkbox"/> Diverticulitis  |
| <input type="checkbox"/> Defibrillator                           | <input type="checkbox"/> Gallstones  |
| <input type="checkbox"/> Heart surgery                           | <input type="checkbox"/> Liver problem/hepatitis                               |
| <input type="checkbox"/> Aneurysm                                | <input type="checkbox"/> Polycystic ovary syndrome                             |
| <input type="checkbox"/> Kidney stones                           | <input type="checkbox"/> Endometriosis   |
| <input type="checkbox"/> Kidney disease                          | <input type="checkbox"/> PMS   |
| <input type="checkbox"/> Bladder conditions                      | <input type="checkbox"/> Currently pregnant                                    |
| <input type="checkbox"/> Enlarged prostate                       | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Migraines                               | <input type="checkbox"/> Benign Tumor  |
| <input type="checkbox"/> Headaches                               | <input type="checkbox"/> Meningioma  |
| <input type="checkbox"/> Stroke                                  | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Sleep apnea                             | <input type="checkbox"/> Anxiety   |
| <input type="checkbox"/> Seizure history                         | <input type="checkbox"/> Insomnia  |
| <input type="checkbox"/> Glaucoma                                | <input type="checkbox"/> Bipolar disorder                                      |
| <input type="checkbox"/> Low thyroid/hypothyroid                 | <input type="checkbox"/> Fibromyalgia  |
| <input type="checkbox"/> High thyroid                            | <input type="checkbox"/> Anemia  |
| <input type="checkbox"/> Parathyroid disease                     | <input type="checkbox"/> Chronic fatigue                                       |
| <input type="checkbox"/> Osteopenia                              | <input type="checkbox"/> Lyme's disease  |
| <input type="checkbox"/> Osteoporosis                            | <input type="checkbox"/> Lupus/connective tissue disease                       |
| <input type="checkbox"/> Arthritis                               | <input type="checkbox"/> Clotting problems                                     |
| <input type="checkbox"/> Rheumatoid arthritis                    | <input type="checkbox"/> DVT (clot in legs)                                    |
| <input type="checkbox"/> Gout                                    | <input type="checkbox"/> Bleeding problems                                     |
| <input type="checkbox"/> Fractures                               | <input type="checkbox"/> Eczema  |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Emphysema                               | <input type="checkbox"/> Shingles  |
| <input type="checkbox"/> Pneumonia                               | <input type="checkbox"/> Rosacea   |
| <input type="checkbox"/> Other breathing problems                | <input type="checkbox"/> Other:  |
| <input type="checkbox"/> Allergies                               |  |

**SURGICAL HISTORY (list all the surgeries you have ever had):**

**PRESCRIPTION MEDICATIONS / SUPPLEMENTS/ OTC MEDS:**

**MEDICATION ALLERGIES:**

**General testing (list if and when you have had any of the following):**

**BLOOD WORK:**

**URINE:**

**CHEST X-RAY:**

**ECG:**

**STRESS TEST:**

**HOLTER MONITOR:**

**ECHO:**

**MAMMOGRAM:**

**BONE DENSITY TEST:**

**COLONOSCOPY:**

**FLU SHOT:**

**PNEUMONIA SHOT:**

**OTHER VACCINES:**

**List doctors you see:**

**GYN:**

**CARDIOLOGY:**

**PULMONARY:**

**ALLERGIST:**

**SURGEON:**

**ORTHOPEDIST:**

**EYE DOCTOR:**

**FOOD ALLERGIES:**

**SMOKING HISTORY:**

- Never smoked
- Quit in year: \_\_\_\_\_ Smoked for # of years: \_\_\_\_\_  
Circle: ½ pack / 1pack / 2packs
- Currently smoking

**ALCOHOL USE:**

- Never drink
- Drinks per week: \_\_\_\_\_ Type: \_\_\_\_\_
- Recovering from alcohol

**FAMILY HISTORY (list the health problems of your family):**

MOTHER:

FATHER:

SISTERS:

BROTHERS:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Other blood-relatives with health problems:

**OCCUPATIONAL HISTORY:**

What do you do for a living:

Any exposure to fumes/chemicals/asbestos:

**REVIEW OF SYSTEMS**

<p><b>GENERAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Sweats</li> <li><input type="checkbox"/> Weight gain</li> <li><input type="checkbox"/> Weight loss</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Hot or cold intolerance</li> <li><input type="checkbox"/> Blood transfusions</li> <li><input type="checkbox"/> Radiation exposure</li> <li><input type="checkbox"/> Swollen glands</li> <li><input type="checkbox"/> Thyroid problems</li> <li><input type="checkbox"/> Excessive hunger</li> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Insomnia</li> </ul> <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rashes</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Easy bruising</li> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Change in skin color</li> <li><input type="checkbox"/> Change in hair</li> <li><input type="checkbox"/> Change in nails</li> <li><input type="checkbox"/> Lumps</li> <li><input type="checkbox"/> Abnormal moles</li> </ul> <p><b>HEAD</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> History of head injury</li> </ul>	<p><b>EYES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Change in vision</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Injuries</li> <li><input type="checkbox"/> Unusual sensations</li> <li><input type="checkbox"/> Severe dryness</li> </ul> <p><b>EARS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> Ringing</li> <li><input type="checkbox"/> Pain</li> </ul> <p><b>NOSE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Injury</li> <li><input type="checkbox"/> Discharge/drip</li> <li><input type="checkbox"/> Loud snoring</li> <li><input type="checkbox"/> Loss of smell</li> </ul> <p><b>MOUTH/THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding gums</li> <li><input type="checkbox"/> Sore throats frequent</li> <li><input type="checkbox"/> Burning in tongue</li> <li><input type="checkbox"/> Loss of taste</li> <li><input type="checkbox"/> Hoarseness</li> </ul> <p><b>NECK</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lumps</li> <li><input type="checkbox"/> Pain</li> </ul> <p><b>CHEST</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Short of breath</li> <li><input type="checkbox"/> Coughing up blood</li> </ul>	<p><b>CARDIAC</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Heart racing</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Murmur</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Short of breath</li> <li><input type="checkbox"/> Rheumatic fever</li> </ul> <p><b>VASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain in legs, calves, thighs with walking</li> <li><input type="checkbox"/> Swelling of legs</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Phlebitis</li> <li><input type="checkbox"/> Loss of hair on legs</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Loss of color or cold</li> </ul> <p><b>BREAST</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lumps</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Tenderness</li> </ul> <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nausea/vomiting</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Swallowing difficulties</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Change in stool</li> <li><input type="checkbox"/> Reflux/indigestion</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Bloating/gas</li> </ul>	<p><b>URINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequency</li> <li><input type="checkbox"/> Urgency</li> <li><input type="checkbox"/> Difficult to start voiding</li> <li><input type="checkbox"/> Incomplete emptying</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Change in color/odor</li> <li><input type="checkbox"/> Urinating during night</li> <li><input type="checkbox"/> Kidney stones</li> <li><input type="checkbox"/> Kidney cysts</li> <li><input type="checkbox"/> Dialysis</li> </ul> <p><b>MALE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lesions on penis</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Difficulty with erections</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Scrotal masses</li> <li><input type="checkbox"/> Hernias</li> <li><input type="checkbox"/> Prostate problems</li> <li><input type="checkbox"/> Low libido</li> </ul> <p><b>FEMALE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lesions</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Severe dryness</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Pain on intercourse</li> <li><input type="checkbox"/> Fertility problems</li> <li><input type="checkbox"/> Irregular periods</li> <li><input type="checkbox"/> Severe menstrual pain</li> <li><input type="checkbox"/> Fibroids</li> <li><input type="checkbox"/> Ovarian cysts</li> <li><input type="checkbox"/> Low libido</li> </ul>	<p><b>MUSCULOSKELETAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle weakness</li> <li><input type="checkbox"/> Muscle cramps</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Muscle stiffness</li> <li><input type="checkbox"/> Restless legs</li> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Joint swelling</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> Back problems</li> <li><input type="checkbox"/> Deformities</li> <li><input type="checkbox"/> Unsteadiness</li> </ul> <p><b>NEUROLOGIC</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Seizure history</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Tingling / burning</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Memory loss</li> <li><input type="checkbox"/> Speech problem</li> <li><input type="checkbox"/> Balance problem</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Mood changes</li> <li><input type="checkbox"/> Frequent anger spells</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Anxiety / panic</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Disorientation</li> <li><input type="checkbox"/> Bipolar</li> <li><input type="checkbox"/> Schizophrenia</li> </ul>
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**Please fill this part out only if you are being seen for weight management**

**WEIGHT HISTORY (IF YOU NEED ADDITIONAL ROOM TO EXPLAIN AN ANSWER, PLEASE USE THE SPACE AT BOTTOM OF THE PAGE OR THE FOLLOWING PAGE):**

Were you overweight as a child:

When did you start gaining weight:

For females: How much weight did you gain and lose with each pregnancy:

What was the lowest weight you have ever had as an adult and when:

What was the highest weight you have ever had and when:

What has been your average weight:

What is your goal weight:

Are you an emotional eater/ explain:

Do you binge (uncontrollable eating excessive amount of food in one sitting) and when:

Are there any foods that trigger bingeing episodes:

Do you graze and what time of the day:

Do you get up during the night to eat:

What time of the day are you the hungriest:

When do you think about food:

Do you prefer to eat alone:

Do you eat in the car or your bedroom:

How many times a week do you order out or eat out:

Have you had anorexia:

Have you been bulimic or do you purge after eating:

Does anybody in your family have history of anorexia or bulimia:

List your typical physical activities during the day:

Do you exercise:

What diets have you tried and what is the longest time you have been on a diet:

Have you ever been on any appetite suppressants either by prescription or over the counter/which:

What do you drink throughout the day:

**FOOD QUESTIONS:**

What kinds of foods do you crave (ie. Carbs, sweets, salty food, etc):

List most common things you eat, what you like to eat, what you want to eat:

Breakfast:

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Snack:

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Lunch:

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Snack:

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Dinner:

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Snack: