

**MERIDIAN MEDICAL GROUP**

**John Gibbs, MD**

**Alexander Shifrin, MD**

**Ronald Matteotti, MD**

**DEPARTMENT OF SURGERY**

**JERSEY SHORE UNIVERSITY MEDICAL CENTER**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Advance Medical Directive: Do you have an Advanced Directive (Medical Power of Attorney, Living Will, Proxy Directive, Instruction Directive, etc.)?**  YES  NO

**If so: Your Health Care Representative is** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_

**Major Complain/Problem:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Date/Onset of Symptoms:** \_\_\_\_\_

**Symptoms include:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Other Conditions/Problems:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**All Previous Operations:** \_\_\_\_\_

**(include Date/Year)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**List All Medication and Dose:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List All Known Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do You Smoke Cigarettes?     YES     NO    How Many Per Day: \_\_\_\_\_

Alcohol Consumption:     YES     NO  
How Often: \_\_\_\_\_

List Immediate (Blood Relatives) Family Member's Age and Health Status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(If not living age and cause of death): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did any Family Members have similar Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any Thyroid and/or Parathyroid Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of Cancer in the Family: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of systems:**

1. Have you been experiencing fever or night sweats, or are you tired all the time?     YES     NO

Describe: \_\_\_\_\_  
\_\_\_\_\_

2. Have you had weight loss over 5 pounds, fatigue, malaise?     YES     NO

Describe: \_\_\_\_\_  
\_\_\_\_\_

3. Do you have eye or vision problems?     YES     NO

Describe: \_\_\_\_\_  
\_\_\_\_\_

4. Do you have any problems with your hearing, ears, nose, mouth, throat, or sores in your mouth?     YES     NO

Describe: \_\_\_\_\_  
\_\_\_\_\_

5. Do you have difficulties swallowing?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
6. Do you have any hoarseness or voice changes?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
7. Do you experience chest pains, difficulty breathing while lying down, rapid heart beat, swelling in your ankles?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
8. Do you have chronic cough, or cough up blood, or wheeze, or have any lung problems?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
9. Do you have a history of radiation?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
10. Do you have wheezing, or experience shortness of breath?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
11. Do you have any problems with indigestion, heartburn, abdominal pains or cramps, difficulty with or change in bowel habits or have you seen blood in the toilet with a bowel movement?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
12. Do you have any known diseases or problems with your stomach, gallbladder, intestines, colon or rectum?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
13. Do you have irregular menstrual periods or vaginal bleeding?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
14. Do you have any known problems or diseases of the kidneys, bladder, prostate, or female organs?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
15. Do you have any problems with your bones, joints, and muscles such as arthritis or rheumatism?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_

16. Do you have any skin disorders or breast problems such as a lump or nipple discharge?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
17. Do you have any nervous disorder, or problems such as numbness, tingling, muscle weakness?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
18. Have you had problems with depression, phobias, suicidal thoughts, hallucinations, or other psychiatric problems?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
19. Do you have diabetes, or known disorders of the adrenal?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
20. Do you have anemia, bleed easily, bruise easily, or have any known blood disorders?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
21. Do you suffer from hay fever, asthma or have any other allergies?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
22. Do you have problems with infections or healing wounds?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
23. Do you have a history of hepatitis?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_
24. Have you ever received a blood or plasma transfusion?  YES  NO  
Describe: \_\_\_\_\_  
\_\_\_\_\_