

PHYSICIAN WEIGHT LOSS PROGRAM

27 E. Chestnut Ave.
Merchantville, NJ 08109
(856) 904-0946

Joseph P. DiRenzo Jr., D.O.
Marc Matozzo, D.O.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____ or Cell # _____

Birth Date: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Emergency Contact: _____ Phone: () _____

Occupation: _____

Are you: Married _____ Single _____ Divorced _____ Widowed _____ ?

Are you ALLERGIC to any medications? Y/N: List: _____

Have you ever been hospitalized? Y/N. Explain: _____

Do you have high blood pressure? Y/N. If so, are you being treated? _____

Are you being treated for any health problems?

Explain: _____

When was your last: Answer all that apply.

Pap smear: _____

EKG: _____

Mammogram: _____

Tetanus Shot: _____

Menstrual Cycle: _____

Flu Shot: _____

Stool Check for Blood: _____

Pneumonia Shot: _____

Blood Test: _____

TB Test (PPD): _____

PSA: _____

Will you be having surgery, requiring anesthesia in the next two weeks? Y/N

Please list ALL Medications you are currently taking, including over the counter:

Social History: Do you smoke? Y/N. If so, how many per day? _____

Do you drink alcohol? Y/N. If so, how many per week? _____

**We do not accept medical insurance for the diet program.

**The office fee will be collected BEFORE you see the doctor.

**If you decide not to begin our diet program your fee will be refunded.