

HARVEY STRAUSS, DPM
MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE: _____ NAME: _____ D.O.B.: _____ AGE: _____

MARITAL STATUS: (CIRCLE ONE) MARRIED / SINGLE / DIVORCED / WIDOWED

NO. OF CHILDREN: _____ OCCUPATION: _____ HEIGHT _____ WEIGHT _____

TOBACCO USE: Y / N QUIT? (DATE) _____
 FREQUENCY : _____ (PER DAY) FOR _____ MONTHS / YEARS.

ALLERGIES: Y / N (IF YES):
TO MEDS?: _____

ALCOHOL USE: Y / N QUIT? (DATE) _____
 FREQUENCY : _____ (PER DAY) FOR _____ MONTHS / YEARS.

NON MEDS?: _____

CAFFEINE INTAKE (COFFEE – TEA – SODA) FREQUENCY: _____ (PER DAY)

PAST ILLNESSES OF YOURSELF AND YOUR FAMILY (PLEASE SELECT IF ANY)

YOU/ YOUR FAMILY

- ALCOHOLISM
- ANEMIA
- ASTHMA
- CANCER/TUMOR
- DIABETES
- DRUG ABUSE
- DEPRESSION
- EPILEPSY / SEIZURES
- GLAUCOMA
- HEART DISEASE

YOU/ YOUR FAMILY

- HIGH BLOOD PRESSURE
- KIDNEY DISEASE
- LIVER DISEASE
- HEPATITIS
- LUNG DISEASE
- MENTAL ILLNESS
- OSTEOARTHRITIS
- OSTEOPOROSIS
- PHLEBITIS
- RHEUM ARTHRITIS

YOU/ YOUR FAMILY

- STROKE
- SUICIDE ATTEMPT
- THYROID DISEASE
- TUBERCULOSIS / TB
- ULCER IN GI TRACT
- VENEREAL DISEASE
- HIGH CHOLESTEROL
- HIV/IMMUNE DX
- OTHER _____

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

REVIEW OF SYSTEMS- PLEASE CHECK “YES” OR “NO” AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:

- WEIGHT LOSS Y / N
- FATIGUE
- FEVER

EYES:

- GLASSES/CONTACTS Y / N
- EYE PAIN
- DOUBLE VISION
- CATARACTS

EAR, NOSE, THROAT:

- DIFFICULTY HEARING Y / N
- RINGING IN EARS
- VERTIGO
- SINUS TROUBLE
- NASAL STUFFINESS
- FREQUENT Sore Throat

CARDIOVASCULAR:

- MURMUR Y / N
- CHEST PAIN
- PALPITATIONS
- DIZZINESS
- FAINING SPELLS
- SHORTNESS OF BREATH
- DIFFICULTY LYING FLAT
- SWELLING ANKLES

ENDOCRINE:

- LOSS OF HAIR Y / N
- HEAT / COLD TOLERANCE

RESPIRATORY:

- COUGH Y / N
- COUGHING BLOOD
- WHEEZING
- CHILLS

GASTROINTESTINAL:

- HEARTBURN/REFLUX Y / N
- NAUSEA/VOMITING
- CONSTIPATION
- CHANGE IN BMs
- DIARRHEA
- JAUNDICE
- ABDOMINAL PAIN
- BLACK OR BLOODY BM

GENITOURINARY:

- BURNING/FREQUENCY Y / N
- NIGHTTIME
- BLOOD IN URINE
- ERECTILE DYSFUNCTION
- ABNORMAL DISCHARGE
- BLADDER LEAKAGE

ALLERGIC/ IMMUNOLOGIC:

- HIVES / ECZEMA
- HAY FEVER
- PSYCHIATRIC:** Y / N
- ANXIETY/DEPRESSION
- MOOD SWINGS
- DIFFICULTY SLEEPING

HEMATOLOGY/LYMPH:

- EASY BRUISING Y / N
- GUMS BLEED EASILY
- ENLARGED GLANDS

MUSCULOSKELETAL:

- JOINT PAIN/SWELLING Y / N
- STIFFNESS
- MUSCLE PAIN
- BACK PAIN

SKIN:

- RASH / SORES Y / N
- LESIONS
- ITCHING / BURNING

NEUROLOGICAL:

- LOSS OF STRENGTH Y / N
- NUMBNESS
- HEADACHES
- TREMORS
- MEMORY LOSS

FEMALES ONLY:

- DATE OF LAST MAMMOGRAM _____
- NORMAL ABNORMAL
- DATE OF LAST PAP _____
- NORMAL ABNORMAL
- AGE ONSET PERIODS _____
- AGE ONSET MENOPAUSE _____
- PERIODS REGULAR? YES NO
- NUMBER PREGNANCIES? _____

SIGNATURE / REVIEWING PHYSICIAN: