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.

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

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

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

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

YOU/ YOUR FAMILY	YOU/ YOUR FAMILY	YOU/ YOUR FAMILY
☐ ☐ ALCOHOLISM	☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ STROKE
☐ ☐ ANEMIA	☐ ☐ KIDNEY DISEASE	☐ ☐ SUICIDE ATTEMPT
☐ ☐ ASTHMA	☐ ☐ LIVER DISEASE	☐ ☐ THYROID DISEASE
☐ ☐ CANCER/TUMOR	☐ ☐ HEPATITIS	☐ ☐ TUBERCULOSIS / TB
☐ ☐ DIABETES	☐ ☐ LUNG DISEASE	☐ ☐ ULCER IN GI TRACT
☐ ☐ DRUG ABUSE	☐ ☐ MENTAL ILLNESS	☐ ☐ VENEREAL DISEASE
☐ ☐ DEPRESSION	☐ ☐ OSTEOARTHRITIS	☐ ☐ HIGH CHOLESTEROL
☐ ☐ EPILEPSY / SEIZURES	☐ ☐ OSTEOPOROSIS	☐ ☐ HIV/IMMUNE DX
☐ ☐ GLAUCOMA	☐ ☐ PHLEBITIS	☐ ☐ OTHER _____
☐ ☐ HEART DISEASE	☐ ☐ RHEUM ARTHRITIS	_____

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____
_____
_____

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

CONSTITUTIONAL:	**Y / N**	**RESPIRATORY:**	**Y / N**	**HEMATOLOGY/LYMPH:**	**Y / N**
WEIGHT LOSS	☐ ☐	COUGH	☐ ☐	EASY BRUISING	☐ ☐
FATIGUE	☐ ☐	COUGHING BLOOD	☐ ☐	GUMS BLEED EASILY	☐ ☐
FEVER	☐ ☐	WHEEZING	☐ ☐	ENLARGED GLANDS	☐ ☐
		CHILLS	☐ ☐	**MUSCULOSKELETAL:**	**Y / N**
EYES:	**Y / N**	**GASTROINTESTINAL:**	**Y / N**	JOINT PAIN/SWELLING	☐ ☐
GLASSES/CONTACTS	☐ ☐	HEARTBURN/REFLUX	☐ ☐	STIFFNESS	☐ ☐
EYE PAIN	☐ ☐	NAUSEA/VOMITING	☐ ☐	MUSCLE PAIN	☐ ☐
DOUBLE VISION	☐ ☐	CONSTIPATION	☐ ☐	BACK PAIN	☐ ☐
CATARACTS	☐ ☐	CHANGE IN BMs	☐ ☐	**SKIN:**	**Y / N**
EAR, NOSE, THROAT:	**Y / N**	DIARRHEA	☐ ☐	RASH / SORES	☐ ☐
DIFFICULTY HEARING	☐ ☐	JAUNDICE	☐ ☐	LESIONS	☐ ☐
RINGING IN EARS	☐ ☐	ABDOMINAL PAIN	☐ ☐	ITCHING / BURNING	☐ ☐
VERTIGO	☐ ☐	BLACK OR BLOODY BM	☐ ☐	**NEUROLOGICAL:**	**Y / N**
SINUS TROUBLE	☐ ☐	**GENITOURINARY:**	**Y / N**	LOSS OF STRENGTH	☐ ☐
NASAL STUFFINESS	☐ ☐	BURNING/FREQUENCY	☐ ☐	NUMBNESS	☐ ☐
FREQUENT Sore Throat	☐ ☐	NIGHTTIME	☐ ☐	HEADACHES	☐ ☐
CARDIOVASCULAR:	**Y / N**	BLOOD IN URINE	☐ ☐	TREMORS	☐ ☐
MURMUR	☐ ☐	ERECTILE DYSFUNCTION	☐ ☐	MEMORY LOSS	☐ ☐
CHEST PAIN	☐ ☐	ABNORMAL DISCHARGE	☐ ☐	**FEMALES ONLY:**	
PALPITATIONS	☐ ☐	BLADDER LEAKAGE	☐ ☐	DATE OF LAST MAMOGRAM _____	
DIZZINESS	☐ ☐	**ALLERGIC/ IMMUNOLOGIC:**		NORMAL ☐ ABNORMAL ☐	
FAINTING SPELLS	☐ ☐	HIVES / ECZEMA	☐ ☐	DATE OF LAST PAP _____	
SHORTNESS OF BREATH	☐ ☐	HAY FEVER	☐ ☐	NORMAL ☐ ABNORMAL ☐	
DIFFICULTY LYING FLAT	☐ ☐	**PSYCHIATRIC:**	**Y / N**	AGE ONSET PERIODS _____	
SWELLING ANKLES	☐ ☐	ANXIETY/DEPRESSION	☐ ☐	AGE ONSET MENOPAUSE _____	
ENDOCRINE:	**Y / N**	MOOD SWINGS	☐ ☐	PERIODS REGULAR? YES ☐ NO ☐	
LOSS OF HAIR	☐ ☐	DIFFICULTY SLEEPING	☐ ☐	NUMBER PREGNANCIES? _____	
HEAT / COLD TOLERANCE	☐ ☐				

SIGNATURE / REVIEWING PHYSICIAN: _____