Robert I. Neufeld, D.P.M., L.L.C.

Podiatric Medicine and Surgery
2092 Morris Avenue Union, New Jersey 07083
Tel. (908) 688-0113 Fax (908) 688-2002

Review of Systems: Please indicate any personal history below:

CONSTITUTIONAL SYMPTOMS

- Good general health lately........................ No Yes
- Recent weight change................................ No Yes
- Fever.. No Yes
- Fatigue... No Yes
- Headaches.. No Yes

EYES

- Eye disease or injury................................ No Yes
- Wear glasses / contact lenses.................. No Yes
- Blurred or double vision........................... No Yes
- Glaucoma.. No Yes

EARS/ NOSE/ MOUTH/ THROAT

- Hearing loss or ringing............................ No Yes
- Earaches or drainage................................ No Yes
- Chronic sinus problem or rhinitis............ No Yes
- Nose bleeds... No Yes
- Mouth sores.. No Yes
- Bleeding gums... No Yes
- Bad breath or bad taste............................ No Yes
- Sore throat or voice change...................... No Yes
- Swollen glands in neck............................. No Yes

CARDIOVASCULAR

- Heart trouble.. No Yes
- Chest pain or angina pectoris.................. No Yes
- Palpitation... No Yes
- Shortness of breath w/ walking/ lying.... No Yes
- Swelling of feet, ankles or hands........... No Yes

RESPIRATORY

- Chronic or frequent coughs..................... No Yes
- Spitting up blood...................................... No Yes
- Shortness of breath.................................. No Yes
- Asthma or wheezing................................. No Yes

GASTROINTESTINAL

- Loss of appetite... No Yes
- Change in bowel movements.................... No Yes
- Nausea or vomiting................................... No Yes
- Frequent diarrhea..................................... No Yes
- Painful bowel movement or constipation No Yes
- Rectal bleeding or blood in stool............ No Yes
- Abdominal pain... No Yes
- Peptic ulcer (stomach or duodenal......... No Yes

GENITOURINARY

- Frequent urination..................................... No Yes
- Burning or painful urination.................... No Yes
- Blood in urine.. No Yes
- Force of strain change when urinating... No Yes
- Incontinence or dribbling......................... No Yes
- Kidney stones.. No Yes
- Sexual difficulty.. No Yes
- Male- testicle pain..................................... No Yes
- Female- pain with periods........................ No Yes
- Female- irregular periods......................... No Yes
- Female- vaginal discharge........................ No Yes
- Female- # of pregnancies..........................______
- Female- # of miscarriages.........................______
- Female- date of last pap smear.................______

MUSCULOSKELETAL

- Joint Pain.. No Yes
- Joint stiffness or swelling......................... No Yes
- Weakness of muscles or joints.................. No Yes
- Muscle Pain or cramps............................... No Yes
- Back Pain.. No Yes
- Cold extremities... No Yes
- Difficulty in walking.................................. No Yes

INTEGUMENTARY (skin, breast)

- Rash or itching.. No Yes
- Change in skin color................................... No Yes
- Change in hair or nails................................ No Yes
- Varicose veins... No Yes
- Breast pain... No Yes
- Breast lump.. No Yes
- Breast discharge... No Yes

NEUROLOGICAL

- Frequent or recurring headaches...... No Yes
- Light headed or dizzy.......................... No Yes
- Convulsions or seizures....................... No Yes
- Numbness or tingling sensations......... No Yes
- Tremors... No Yes
- Paralysis.. No Yes
- Stroke.. No Yes
- Head injury.. No Yes

PSYCHIATRIC

- Memory loss or confusion................... No Yes
- Nervousness... No Yes
- Depression.. No Yes
- Insomnia... No Yes

ENDOCRINE

- Glandular or hormone problem........ No Yes
- Thyroid disease.................................... No Yes
- Diabetes *circle one-insulin or non insulin* ..... No Yes
- Excessive thirst or urination................ No Yes
- Heat or cold intolerance....................... No Yes
- Skin becoming drier.............................. No Yes
- Change in hat or glove size.................. No Yes

HEMATOLOGY/ LYMPHATIC

- Slow to heal after cuts.......................... No Yes
- Bleeding or bruising tendency.............. No Yes
- Anemia.. No Yes
- Phlebitis.. No Yes
- Past transfusion...................................... No Yes
- Enlarged glands...................................... No Yes

ALLERGIC/ IMMUNOLOGIC

History of skin reaction or adverse reaction to:

- Penicillin or other antibiotics................No Yes
- Morphine,Demerol or other narcotics No Yes
- Novocain or other anesthetics.............. No Yes
- Aspirin or other pain remedies............ No Yes
- Tetanus antitoxin or other serums..... No Yes
- Iodine, methiolate or other antisept..... No Yes
- Other drugs/medications:______________
- Known food allergies:__________________
- Environmental allergies:_______________

Patient name:______________________ Signature:______________________ Date:__________