BRUSH OPTICAL
MEDICAL HISTORY AND REVIEW OF SYSTEMS

Patient Name______________________________ Date of Birth______________________

Primary Care Physician's Name____________________ Date of Last Physical____________________

REVIEW OF SYSTEMS: Do **YOU** take medication for, or have **YOU** had any problems/treatment of any kind for any of the following conditions? **(Please check YES or NO for each)**

☐ **None**

CONSTITUTIONAL	**YES**	**NO**	**What Year?**
Fever, Weight changes, Fatigue	☐	☐	______

CARDIOVASCULAR	**YES**	**NO**	
Heart Disease	☐	☐	______
High Blood Pressure	☐	☐	______
Vascular Disease	☐	☐	______
Heart Attack	☐	☐	______
Stroke	☐	☐	______
High Cholesterol	☐	☐	______

EARS, NOSE, MOUTH, THROAT	**YES**	**NO**	
Allergies/Hay Fever	☐	☐	______
Sinus Congestion	☐	☐	______
Chronic Cough	☐	☐	______
Dry Throat/Mouth	☐	☐	______

RESPIRATORY	**YES**	**NO**	
Asthma	☐	☐	______
Chronic Bronchitis	☐	☐	______
Emphysema/Lung Disease	☐	☐	______

GASTROINTESTINAL	**YES**	**NO**	
Diarrhea	☐	☐	______
Constipation	☐	☐	______

GENITOURINARY	**YES**	**NO**	
Genitals/Urinary/Bladder	☐	☐	______
Kidney Disease	☐	☐	______
AIDS, Syphillis, Gonorrhea	☐	☐	______

ALLERGIC/IMMUNOLOGIC	**YES**	**NO**	
Autoimmune disorders	☐	☐	______
Lupus	☐	☐	______

	YES	**NO**
Are you currently pregnant?	☐	☐
How many months? ________		
Are you currently nursing?	☐	☐

MUSCULOSKELETAL	**YES**	**NO**	**What Year?**
Osteo or Rheumatoid Arthritis	☐	☐	______
Muscle Pain	☐	☐	______
Joint Pain	☐	☐	______
Artificial Joints	☐	☐	______
Fibromyalgia	☐	☐	______
Muscular Dystrophy	☐	☐	______

INTEGUMENTARY (Skin)	**YES**	**NO**	
Rosacea	☐	☐	______
Skin Cancers	☐	☐	______

NEUROLOGICAL	**YES**	**NO**	
Headaches	☐	☐	______
Migraines	☐	☐	______
Bell's Palsy	☐	☐	______
Epilepsy/Seizures	☐	☐	______
Multiple Sclerosis	☐	☐	______
Shingles	☐	☐	______

PHYCHIATRIC	**YES**	**NO**	
Depression/Anxiety	☐	☐	______
Bipolar disorders	☐	☐	______

HEMATOLOGIC/LYMPHATIC	**YES**	**NO**	
Anemia	☐	☐	______
Bleeding Problems	☐	☐	______

ENDOCRINE	**YES**	**NO**	
Thyroid/Other Glands	☐	☐	______
Diabetes	☐	☐	______

Diabetes Related:

Last A1C Level____________________

Average glucose level________________

HEIGHT________________________

WEIGHT________________________

BLOOD PRESSURE__________________

If you have a condition not listed above, please explain, list medications and year.__________________________

____

Doctor's Signature______________________________________ **Date**____________________