Optimum Health/David Miloy MD PA
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History Form

Patient Name: _____ Date: _____ Please check all that you have a personal history of:

( ) Asthma
( ) COPD
( ) Pneumonia
( ) High blood pressure
( ) High cholesterol
( ) Heart attack
( ) Heart murmur
( ) Artificial heart valve
( ) Atrial Fibrillation
( ) Eye disease
( ) Hearing disorder
( ) Cancer: type_____
( ) Seizures
( ) Migraines
( ) Stroke
( ) Neck/back pain
( ) Osteoporosis

( ) Kidney disease
( ) Hepatitis
( ) Incontinence
( ) GERD (reflux)
( ) Diabetes
( ) HIV
( ) Anemia
( ) Bleeding disorder
( ) Blood clot
( ) Thyroid disorder
( ) Depression
( ) Anxiety
( ) Mental illness: Type_____
( ) Fibromyalgia
( ) Other: _____
_____
_____

Please list all surgeries and date of surgeries if known:
_____
_____
_____

Please list all hospitalizations:
_____
_____
_____

Please list all doctors that you currently see:
_____
_____
_____

Social History: Marital Status: (circle one) Single Married Widowed Divorced
Do you use alcohol? YES or NO If yes, how many drinks per week? ___ per day? ___
Do you use tobacco or e- cigarette? YES or NO. If yes, what type_____
If YES, How much per day? _____ Age started? ____ Age Quit? _____
Recreational drug use? Type? _____

Employment status (circle) WORKING RETIRED DISABLED: reason_____
Occupation: _____
Do you always wear a seatbelt? YES or NO ____
Do you have children? YES or NO___ If yes, what are their birth years?_____

Family History:

Father: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Mother: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Brothers: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Sisters: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Family history of alcohol abuse? Yes or no____
Family history of depression? Yes or no____

Immunizations/Screening Tests:

Tetanus vaccination_____ Pneumonia vaccination_____ Shingles vaccination_____ Gardasil/HPV vaccination_____ Hepatitis B vaccination_____ Flu vaccination_____ Tdap vaccination_____ PPD(TB test)_____ Colonoscopy_____ PSA_____ Eye exam_____ Stress test_____ Bone density test_____ Sleep study_____ Mammogram_____

Review of Systems:
(Please circle any of the following that you are experiencing)

weight loss/gain
fevers
headaches
rash
itching
leg swelling
hives
congestion
ear pain
sore throat
chest pain

Review of Systems Continue:

palpitations
cough
wheezing
shortness of breath
nausea diarrhea
abdominal pain
urinary frequency
incontinence
burning with urination
vaginal discharge
irregular periods
erectile dysfunction
joint pain
muscle spasm neck/back pain
heat/cold intolerance
seizures
numbness
dizziness
depression
anxiety
trouble sleeping

Other: _____

Medication Allergies:

_____
_

Other Allergies:

_____
_

Medications:

	Name	*Dose*	*Frequency*		*Name*	*Dose*	*Frequency*
1.				8.			
2.				9.			
3.				10.			
4.				11.			
5.				12.			
6.				13.			
7.				14.			

Advanced Directives:

Do you have a Living Will? Yes or no_____ Do you have a Power of Attorney for health care?

Yes or no_____ If yes, Name/Phone #_____