Millar
Functional Medicine

Patient's Label

CONFIDENTIAL HEALTH INFORMATION Today's Date_____

Name (Last, First, MI) _____Date of Birth_____

GENERAL INFORMATION

□ Male □ Female Race _____ Height_____'_____" Weight _____lbs
Name of your primary care physician _____Phone_____
Are you currently seeing other physicians or therapists for these problems □ Yes □ No
Are you currently on disability □ Yes □ No For: _____
The reason for this visit: _____ as a result of □ Work □ Accident □ Sports □ Other
Do you smoke or chew □ Yes □ No Do you drink alcohol □ Never □ Socially □ Occasionally □ Frequently
Do you currently exercise □ Never □Occasionally □ Regularly □ Stopped due to _____

HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS

□ Y □ N Heart Attack/ Stroke/ TIA
□ Y □ N Diabetes Type I Type II
□ Y □ N Alcohol/Drug Abuse
□ Y □ N Heart Disease or Surgery
□ Y □ N Congestive Heart Failure
□ Y □ N High/Low Blood Pressure
□ Y □ N Pacemaker/ Defibrillator
□ Y □ N Carotid Artery Blockage
□ Y □ N Artificial Bones/Joints
□ Y □ N Osteoporosis
□ Y □ N Arthritis OA or RA
□ Y □ N Fibromyalgia/ Lupus/ MS
□ Y □ N Peripheral Artery Disease

□ Y □ N Neck or Back Pain
□ Y □ N Neck or Back Surgery
□ Y □ N Anemia or Blood Problems
□ Y □ N COPD or Lung Problems
□ Y □ N Hepatitis/ Liver Problems
□ Y □ N Kidney Problems or Failure
□ Y □ N Cancer
□ Y □ N Chemotherapy/ Radiation
□ Y □ N High Cholesterol / High A1C
□ Y □ N Heavy Medal Exposure
□ Y □ N Edema or swelling of legs
□ Y □ N Restless Leg Syndrome
□ Y □ N Neuropathy

Do you have any of the following problems?
Write In: **N** = None **O** = Occasional
C = Continuous **F** = Frequent

_____ Neck Pain
_____ Mid Back Pain
_____ Low Back Pain
_____ Sacral Pain
_____ Pelvis Pain
_____ Hip Pain
_____ Leg Pain
_____ Knee Pain
_____ Ankle Pain
_____ Foot Pain
_____ Toe Pain

_____ Shoulder
_____ Elbow Pain
_____ Wrist Pain
_____ Hand Pain
_____ Finger Pain
_____ Thumb Pain
_____ Whole Body
_____ Headaches
_____ Migraines
_____ TMJ Pain
_____ Rib Pain

List other medical conditions you have had _____

_____

Surgeries (Please list ALL surgical procedures that you have had in the past.)_____

_____

Injuries (Please list any significant injuries, falls, trauma or non motor vehicle accidents you have had in the past.)_____

_____

Motor Vehicle Accidents (Please list any past MVA's, year and list injuries sustained.)_____

_____

List any **MRI's, Cat Scans, or Pet Scans** in the past. Include date and region _____

_____

FAMILY HISTORY

Family	Alive	Deceased	Health Conditions/Diseases/Conditions
Father	□	□	_____
Mother	□	□	_____
Paternal Grandfather	□	□	_____
Paternal Grandmother	□	□	_____
Maternal Grandfather	□	□	_____
Maternal Grandmother	□	□	_____

Patient Initial _____

Millar
Functional Medicine

Recent Doctor visits or ER visits

Have you been to the ER in the past 6 months □ Yes □ No If Yes then fill in below

Date	What Hospital /City/ State	Treated For / Treatment

Have you been to the Doctor in the past 6 months □ Yes □ No If Yes then fill in below

Date	Name of Doctor /City /State	Treated For / Treatment

Medication Log

Name of Medication	Dosage	Qty	Purpose	Prescribing Physician

Vitamins and Supplements

Name of Vitamin/ Supplement	Dosage	Qty	Purpose

List anything you may be allergic to _____