Millar Functional - Review of Systems

Patient Name: _____ **Today's Date:** ____/____/_____

INSTRUCTIONS: **Please select Current if you it NOW. Please select PAST if you had in the past but no longer.**
If never had the condition then select NONE. ***Please take your time and answer completely!***

Constitutional:	**Current**	**Past**	**None**
Alcohol or Drug Abuse	☐	☐	☐
Arthritis OA | RA	☐	☐	☐
Artificial Bones or Joints	☐	☐	☐
Blood Pressure: ☐ High ☐ Low	☐	☐	☐
Cancer of _____	☐	☐	☐
Chemotherapy	☐	☐	☐
Chills	☐	☐	☐
Do you feel well: ☐ Yes ☐ No	☐	☐	☐
Daytime drowsiness	☐	☐	☐
Fatigue	☐	☐	☐
Fever (☐ Recent or ☐ Chronic)	☐	☐	☐
Fracture of _____	☐	☐	☐
Guillain-Barre Syndrome	☐	☐	☐
Hepatitis	☐	☐	☐
HIV+ / AIDS	☐	☐	☐
Lyme Disease	☐	☐	☐
Mumps / Measles	☐	☐	☐
Night Sweats	☐	☐	☐
Osteoporosis | Osteopenia	☐	☐	☐
Polio or Post Polio	☐	☐	☐
Recent or chronic Infection	☐	☐	☐
Recent Changes to Bowel	☐	☐	☐
Rheumatic or Yellow Fever	☐	☐	☐
Scarlet Fever /Typhoid	☐	☐	☐
Shingles	☐	☐	☐
Weight Loss past 6 months	☐	☐	☐
Venereal Disease	☐	☐	☐

Allergy:	**Current**	**Past**	**None**
Anaphylaxis (*history of*)	☐	☐	☐
Food allergies	☐	☐	☐
Itching	☐	☐	☐
Nasal Congestion	☐	☐	☐
Seasonal allergies	☐	☐	☐
Sneezing	☐	☐	☐

Teeth and Dental:	**Current**	**Past**	**None**
Amalgams. How many?_____	☐	☐	☐
Dentures or implants	☐	☐	☐
Extractions	☐	☐	☐
Root Canals or Crowns	☐	☐	☐

Eyes/Vision:	**Current**	**Past**	**None**
Blindness	☐	☐	☐
Blurred Vision	☐	☐	☐
Cataracts/Cataract Surgery	☐	☐	☐
Change in Vision	☐	☐	☐
Double Vision	☐	☐	☐
Eye Pain	☐	☐	☐
Eye Movement Disorders	☐	☐	☐
Glaucoma	☐	☐	☐
Wears Glasses or Contacts	☐	☐	☐

Ears, Nose and Throat:	**Current**	**Past**	**None**
Chronic Cough	☐	☐	☐
Dental Implants | Dentures	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Dizziness | Vertigo	☐	☐	☐
Ear Drainage	☐	☐	☐
Ear Infection(s)	☐	☐	☐
Ear Pain	☐	☐	☐
Headaches (Sinus) (Other)	☐	☐	☐
Head Injury- Current | Past	☐	☐	☐
Hearing Loss	☐	☐	☐
Hoarseness	☐	☐	☐
Loss of Smell	☐	☐	☐
Nasal Congestion	☐	☐	☐
Nose bleeds (*frequent*)	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Rhinorrhea (*runny nose*)	☐	☐	☐
Sinus Infections	☐	☐	☐
Snoring	☐	☐	☐
Sore Throats	☐	☐	☐
Tinnitus -*ringing in the ears*	☐	☐	☐
TMJ Disorder	☐	☐	☐

Skin:	**Current**	**Past**	**None**
Changes in Nail Texture	☐	☐	☐
Changes in Skin Color	☐	☐	☐
Hair Growth	☐	☐	☐
Hair Loss	☐	☐	☐
History of Skin Disorders	☐	☐	☐
Itching | Rash | Hive	☐	☐	☐
Paresthesia (numbness, prickling, or tingling)	☐	☐	☐
Skin Lesions or Ulcers	☐	☐	☐
Varicosities	☐	☐	☐

Respiration:	**Current**	**Past**	**None**
Asthma	☐	☐	☐
Blood Production	☐	☐	☐
Bronchitis	☐	☐	☐
COPD	☐	☐	☐
Difficulty Breathing	☐	☐	☐
Emphysema	☐	☐	☐
Shortness of Breath	☐	☐	☐
Sleep Apnea	☐	☐	☐
Tuberculosis	☐	☐	☐
Use C-Pap or B-Pap	☐	☐	☐
Wheezing	☐	☐	☐

Cardiovascular:	**Current**	**Past**	**None**
Angina (*chest pain*)	☐	☐	☐
Artificial Valves	☐	☐	☐
Carotid Artery Blockage	☐	☐	☐
Carotid Artery Ultrasound	☐	☐	☐
Chest Pain Other causes	☐	☐	☐
Claudication (*leg pain*)	☐	☐	☐
Congenital Heart Defect	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Deep Vein Thrombosis	☐	☐	☐
Heart Attack | Stroke | TIA	☐	☐	☐
Heart Murmur	☐	☐	☐
Heart Disease or Problems	☐	☐	☐
Heart Stint/bypass Surgery	☐	☐	☐
Orthopnea (*difficulty breathing while lying down*)	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Palpitations (*irregular or rapid heart beat*)	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Shortness of Breath	☐	☐	☐

Swelling of Leg(s)	☐	☐	☐
Ulcers	☐	☐	☐
Varicose Veins	☐	☐	☐

Gastrointestinal:	**Current**	**Past**	**None**
Abdominal Pain	☐	☐	☐
Belching	☐	☐	☐
Black, Tarry Stools	☐	☐	☐
Constipation or Diarrhea	☐	☐	☐
Colitis or Celiac Disease	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Indigestion	☐	☐	☐
Jaundice (*yellowing skin*)	☐	☐	☐
Nausea	☐	☐	☐
Rectal Bleeding	☐	☐	☐
Abnormal Stool Caliber	☐	☐	☐
Abnormal Stool Color	☐	☐	☐
Abnormal Stool Size	☐	☐	☐
Ulcers	☐	☐	☐
Vomiting	☐	☐	☐

Female:	**Current**	**Past**	**None**
Birth Control _____	☐	☐	☐
Breast Lumps / Pain	☐	☐	☐
Burning Urination	☐	☐	☐
Cramps	☐	☐	☐
Frequent Urination	☐	☐	☐
Hormone Therapy	☐	☐	☐
Irregular Menstruation	☐	☐	☐
Urine Retention	☐	☐	☐
Vaginal Bleeding	☐	☐	☐
Vaginal Discharge	☐	☐	☐

Nervous System:	**Current**	**Past**	**None**
Balance Issues	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting | Syncope	☐	☐	☐
Facial Weakness	☐	☐	☐
Headaches or Migraines	☐	☐	☐
Limb Weakness	☐	☐	☐
Loss of Consciousness	☐	☐	☐
Loss of Memory	☐	☐	☐
Numbness of _____	☐	☐	☐
Seizures	☐	☐	☐
Sleep Disturbance	☐	☐	☐
Slurred Speech	☐	☐	☐
Stress	☐	☐	☐
Tremors	☐	☐	☐
Unsteadiness of Gait	☐	☐	☐
Urine Retention	☐	☐	☐

Psychological:	**Current**	**Past**	**None**
Anxiety	☐	☐	☐
Appetite Changes	☐	☐	☐
Attempted Suicide	☐	☐	☐
Behavioral Change(*s*)	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Confusion	☐	☐	☐
Convulsions	☐	☐	☐
Depression	☐	☐	☐
Hospitalized for evaluation	☐	☐	☐
Insomnia	☐	☐	☐
Memory Loss	☐	☐	☐
Mood Change(*s*)	☐	☐	☐
Psychiatric Problems	☐	☐	☐
PTSD	☐	☐	☐
Sadness | Tearfulness	☐	☐	☐

Hematology:	**Current**	**Past**	**None**
Anemia	☐	☐	☐
Bleeding or bleed easy	☐	☐	☐
Blood Clotting Issues	☐	☐	☐
Blood Disease(s)	☐	☐	☐
Blood Disease(s)	☐	☐	☐
Bruises Easily	☐	☐	☐
Lymph Node Swelling	☐	☐	☐

Male:	**Current**	**Past**	**None**
Burning Urination	☐	☐	☐
Erectile Dysfunction	☐	☐	☐
Frequent Urination	☐	☐	☐
Hesitancy or Dribbling	☐	☐	☐
Prostate Problems	☐	☐	☐
Urine Retention	☐	☐	☐

Endocrine:	**Current**	**Past**	**None**
Cold/ Heat Intolerance	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Excessive Appetite	☐	☐	☐
Excessive Hunger	☐	☐	☐
Excessive Thirst	☐	☐	☐
Frequent Urination	☐	☐	☐
Goiter	☐	☐	☐
Hair Loss	☐	☐	☐
Renal or Kidney problems	☐	☐	☐
Thyroid Disorders	☐	☐	☐
Unusual Hair Growth	☐	☐	☐
Voice Changes	☐	☐	☐

Other not listed:	**Current**	**Past**	**None**
_____	☐	☐	☐
_____	☐	☐	☐

I agree that it will be my responsibility to keep this information up to date. I will report any changes to my conditions, diagnosis, or symptoms. I understand that the providers (Doctors) I am seeing shall NOT act as my primary care physician. The Millar Functional Medicine practice is limited to chronic functional medicine conditions and diseases. I further assume full responsibility for seeking other doctors or treatments for my acute conditions, diagnosis or symptoms named above or my chronic conditions named above that become acute conditions in the future so additional testing, treatment or hospitalization may be done for my acute conditions, diagnosis or symptoms.

Patient Signature: _____ Doctor Signature: _____ **MFM Form D** 07.15.2025