FERTILITY
and beyond

Please fill this out and save the file as 'your name initial patient form' and email it back to me at kathryn@fertilityandbeyond.co
Please attach any relevant blood test results from the past 18 months.
Please highlight in a colour or make bold any answers that are correct for you.

Date:

Name::	Orson Stewart	DOB:: 1/25/1970	Age:: 52
Address::	5230 Tuckerman Lane, #1423 Rockville, MD	Postcode:: 20852	
Phone::	Occupation:: Medical Resident	Blood type ::	
Next-of-kin::	R/ship to patient: Partner	Telephone:: 202-368-4318	
Email address::	DURRANT_STEWART@YAHOO.COM		

Private Health Insurer _____

Referred by :: Partner

- Friend / Word of mouth
- Doctor/Midwife/ Practitioner Name of referee :: _____
- Direct search for Kathryn Moloney Naturopath
- Google search (what did you search for?) _____
- Other online advertiser _____
- Other _____

What would you like to achieve from naturopathic treatment?

Improve sperm health - currently 99% abnormal

Current medication (please list name of medication, what you are using it for and dosage)?	Natural medicines/vitamins (if so, please list)?
Propranolol, lisinopril hydrochlorothiazide	None

Do you give permission for me to contact your doctor/obstetrician/practitioner if relevant? Yes/No Yes
Name and address of your Doctor &/or Obstetrician &/or Practitioner:

Am I able to discuss your health and test results with your partner if required? Yes/No Yes

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Main reason for your appointment (please include your symptoms and duration)::

Support sperm health for conception. My semen analysis is abnormal.

Allergies (environmental, medicine or food-related)?	**Operations?**
Major illness as a child/teenager? None	**Regular exercise (type and how often)?** 2 times per day - run

FAMILY HISTORY: Do your parents, grandparents or siblings suffer from any of the following: (please highlight)

Allergies Arthritis Cancer Depression Diabetes Hay fever Heart disease

Hepatitis High blood pressure X High Cholesterol Kidney problems Liver disease

Thyroid problems Any other major health problems?

GENERAL HEALTH

In order for me to get a better idea of how your body is functioning as a whole, it is important to see how the systems of your body are functioning. Under each section, please indicate if you suffer from any of the listed problems highlighting the correct response or answering in the space provided.

Do you **currently** suffer from any of the following? (Please highlight)

HEAD/NECK:

Dandruff Sore neck/neck problems X Headaches X Migraines X
Swollen glands in neck Dizziness/light headedness Excess hair loss

EYES/EARS/NOSE/MOUTH: None

Blurred vision	Frequent cold/flu	Ringing in the ear	Cold sores
Frequent nose bleeds	Runny nose	Dry, cracked lips	Hay fever
Sinus problems	Dry eyes	Poor vision	Styes/eye blisters
Dry mouth	Puffy eyes	Tired, watery eyes	Ear aches
Bleeding gums	Trouble hearing	Red eyes	Eyelid twitches

RESPIRATORY: No respiratory issues

Any lung problems	Frequent coughing	Shortness of breath	Asthma
Hoarse voice	Sneezing attack	Bronchitis	Irregular breathing
Sore throat			

How many times a year do you suffer from cold/flu?

SKIN: No skin issues

Acne	Eczema/Dermatitis	Oily skin	Bruise easily
Psoriasis	Flaky skin	Cracked skin	Itchy skin
Skin rashes	Dry skin	Cuts/wounds take a long time to heal	

URINARY: No urinary issues

Blood in the urine Pain or burning upon urination Frequent urination
Urination during night
Colour of urine ::
Have you ever suffered from any urinary infections? Yes/No
Have you ever had any kidney problems? Yes/No

DIGESTIVE: None

Flatulence, wind, gas	Bad breath	Frequent vomiting
Itchy anus	Fatigue relieved by eating	Faintness if meals delayed
Laxatives used often	Difficulty swallowing	Stomach pains
Haemorrhoids	Nervous/"butterfly stomach"	Indigestion
Excessive appetite	Heartburn	Reduced appetite

Bloating around your stomach after meal	Yes/No
Burning stomach sensations relieved by eating	Yes/No
Need to eat often or get hunger pains or faintness	Yes/No
Eat a lot but never seem to gain weight	Yes/No
Heart palpitations if meals missed or delayed	Yes/No
History of gallstones or gallbladder attacks	Yes/No

How often do you have a bowel motion (e.g. once a day, once a week etc.)? Every other day

Is your bowel movement: well formed loose consists of many pieces

Do you ever see undigested food in your bowel movement?	Yes/No No
Is there any bleeding or mucus associated with passing a bowel motion?	Yes/No No
Do you suffer from diarrhoea or constipation, or both?	Yes/No/Both No

LIVER:

Are you hungry when you wake in the morning? Yes/No No
How soon after waking do you feel hungry? Immediately Within: ½ hr 1 hr 2 hrs 3hrs Lunch X
How do you feel after eating fatty food? Normal Sluggish Nauseous Other

HEART/CIRCULATION:

Burning feet	Low blood pressure	Swollen ankles
Cold feet/hands	Palpitations	Varicose veins
Chest pain	High blood pressure X	High cholesterol
Chest pain on exertion		

MUSCULOSKELETAL: None

Joint pain Muscle aches Joint stiffness after rising Muscle cramps

BLOOD SUGAR: N/A

Diabetes	Crave sugar If so, what time of day?
Get shaky or irritable when hungry	Feel tired after eating
Abnormal thirst	Irritable before meals
Crave sweet food or coffee in the afternoon	

OTHERS: None

Can't gain weight	Have trouble losing weight	Get "drowsy" often
Night sweats	Intolerance to heat	Intolerance to cold
Sweat excessively	Feel cold more than others	

REPRODUCTIVE:

Difficulty in urinating	Difficulty maintaining the flow of urine	
Prostrate problems	Reduced sexual desire X	Erectile dysfunction X

If you have children, did your partner have any trouble conceiving? Yes/No N/A
If yes, do you know why?
Did you have a sperm analysis? Yes/No
If yes, do you know if there were any problems with it?

LIFESTYLE:

Do you:

- Smoke? No (If yes, how often and how long have you been a smoker?)
  Have you been a smoker in the past? Yes/No No
- Drink alcohol? If yes, how many glasses would you have an average per week? 1 glass of wine or cocktail per week
- Take any social/recreational drugs? (e.g. marijuana) Yes/No No
  Have you taken any in the past? Yes/No No

SLEEP:

Do you have difficulty getting off to sleep? Yes/No Yes - do to neck injury
(If so, please indicate how long it usually takes you to fall asleep)

Do you wake often during the night? Yes/No No
(If so, do you have difficulty getting back to sleep?)

How many hours sleep do you get per night? 8 hours

Do you wake in the morning feeling refreshed? Yes/No Sometimes

ENERGY:

How are your energy levels most of the time?
Please rate your energy levels out of 10 (10 = maximum energy, 0 = extremely fatigued)
Upon waking 8/10 Mid-morning 8 /10 Mid-afternoon 8 /10
Evening 8/10

If you have not rated your energy levels as 10/10, then please indicate when they were last 10/10.

NERVOUS SYSTEM: None

Anxiety	Irritability	Poor concentration	Blackouts
Mood swings	Poor memory	Depression	Panic attacks
Trembling/Shakiness	Fainting		

Do you feel like you are under a lot of stress? Yes/No - Yes

If yes, what is causing your stress?

Unemployment - seeking medical residency

Do you have any techniques for dealing with stress? No

Is there anything else that you would like to tell me? No

I, Orson Stewart have been advised by Kathryn Moloney, that she is not a medical doctor and that this clinic is not a medical practice. As such Kathryn Moloney does not practice or prescribe allopathic medicine. I understand that she is a naturopath & herbalist by Australian training. As such she seeks to activate and support the self-healing mechanisms of the body. She utilises Naturopathic Medicines and encourages Preventative Health Care in the form of dietary, exercise, lifestyle & attitude management.

Y (please highlight) I give my permission for my health history to be kept on file for the purpose of naturopathic care planning &prescribing.

Y I give Kathryn Moloney permission to access past & current records from other health professionals I have, or am seeing as appropriate.

Y I give Kathryn Moloney permission to allow my spouse/other Nadine Linday to take messages by phone regarding my care or pick up naturopathic medicines for me as appropriate.

To the best of my ability all the information given here is a true and accurate representation of my /my child's health.

Signed	Orson Stewart	Date	11/5/2023
Signature Parent or Guardian (for children under age 18 yrs)		Date	

Thank you for taking the time to fill out this form. I look forward to speaking with you further.

Kathryn Moloney BHSc. (Naturopathy)
***.fertilityandbeyond.co
hello@fertilityandbeyond.co