



# Matthew Fisel, ND

NATUROPATHIC PHYSICIAN

## PATIENT PROFILE

**NOTE:** Naturopathic care is only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire.

Patient Name \_\_\_\_\_ Age \_\_\_ Date of Birth \_\_/\_\_/\_\_\_\_ Sex: F M

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

SSN \_\_\_ - \_\_\_ - \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Provider \_\_\_\_\_

Referring Physician \_\_\_\_\_

How Did You Hear About Us?

\_\_\_\_\_

Reason for Visit Today:

\_\_\_\_\_

Primary Health Concerns (in order of importance):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## **HISTORY OF PRESENT ILLNESS/REVIEW OF SYPTOMS**

Please mark "now" or "past" next to all areas that apply to your past and present health

### **HEENT**

\_\_\_ headaches

\_\_\_ earaches

\_\_\_ neck lumps/swelling

\_\_\_ dizziness

\_\_\_ ringing in ears

\_\_\_ dental problems

\_\_\_ blurry Vision

\_\_\_ difficulty hearing

\_\_\_ sore throat

\_\_\_ fainting/blackouts

\_\_\_ nosebleeds

\_\_\_ sore/bleeding gums

\_\_\_ loss of balance

\_\_\_ loss of smell

\_\_\_ difficulty swallowing

\_\_\_ eye pain/red eye

\_\_\_ hoarse voice

\_\_\_ cold or canker sore

\_\_\_ cataracts/glaucoma

\_\_\_ grinding teeth

\_\_\_ impaired speech

**Chest**

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> wheezing            | <input type="checkbox"/> chest colds  | <input type="checkbox"/> unexplained fever      |
| <input type="checkbox"/> cough up blood      | <input type="checkbox"/> palpitations | <input type="checkbox"/> rapid/skipped beats    |
| <input type="checkbox"/> cough up phlegm     | <input type="checkbox"/> chest pain   | <input type="checkbox"/> high blood pressure    |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> night sweats | <input type="checkbox"/> swollen feet or ankles |

**Abdomen**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> stomach pain         | <input type="checkbox"/> constipation       | <input type="checkbox"/> loss of appetite    |
| <input type="checkbox"/> indigestion          | <input type="checkbox"/> diarrhea           | <input type="checkbox"/> excessive appetite  |
| <input type="checkbox"/> nausea               | <input type="checkbox"/> vomiting           | <input type="checkbox"/> blood in stool      |
| <input type="checkbox"/> blood in vomit       | <input type="checkbox"/> gas/bloating       | <input type="checkbox"/> light colored stool |
| <input type="checkbox"/> yellow skin/jaundice | <input type="checkbox"/> clay colored stool | <input type="checkbox"/> rectal pain/itching |

**Genitourinary**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> frequent urination   | <input type="checkbox"/> blood in urine      | <input type="checkbox"/> recurrent bladder infections   |
| <input type="checkbox"/> urge to urinate      | <input type="checkbox"/> kidney stones       | <input type="checkbox"/> genital sores                  |
| <input type="checkbox"/> incontinence         | <input type="checkbox"/> sexual difficulty   | <input type="checkbox"/> sexually transmitted infection |
| <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> pain with urination | <input type="checkbox"/> genital discharge              |

**Musculoskeletal**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> aching muscles    | <input type="checkbox"/> broken bones   | <input type="checkbox"/> sore joints   |
| <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> weakness       | <input type="checkbox"/> leg cramps    |
| <input type="checkbox"/> restless legs     | <input type="checkbox"/> swollen joints | <input type="checkbox"/> tender points |

**Skin**

- |                                  |                                  |  |
|----------------------------------|----------------------------------|--|
| <input type="checkbox"/> acne    | <input type="checkbox"/> rashes  | <input type="checkbox"/> easy bruising |
| <input type="checkbox"/> itching | <input type="checkbox"/> lesions | <input type="checkbox"/> hives         |

**Endocrine**

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> always cold | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> carbohydrate cravings |
| <input type="checkbox"/> always hot  | <input type="checkbox"/> weakness        | <input type="checkbox"/> increased thirst      |

**Nervous**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> anxiety           | <input type="checkbox"/> foggy thinking   | <input type="checkbox"/> loss of memory        |
| <input type="checkbox"/> loss of sensation | <input type="checkbox"/> lack of strength | <input type="checkbox"/> lack of concentration |
| <input type="checkbox"/> tremor            | <input type="checkbox"/> convulsions      | <input type="checkbox"/> paralysis             |

**Blood, Immune**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> painful lymph nodes | <input type="checkbox"/> anemia          | <input type="checkbox"/> swollen glands     |
| <input type="checkbox"/> frequent bleeding   | <input type="checkbox"/> fluid retention | <input type="checkbox"/> wounds heal slowly |

**Male Reproductive**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> prostate problems | <input type="checkbox"/> infertility                         | <input type="checkbox"/> swelling, pain in testicles  |
| <input type="checkbox"/> painful erection  | <input type="checkbox"/> discharge                           | <input type="checkbox"/> trouble maintaining erection |
| <input type="checkbox"/> painful urination | <input type="checkbox"/> difficulty or premature ejaculation |   |

**Female Reproductive**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> lumps in breast(s)    | <input type="checkbox"/> pelvic pain       | <input type="checkbox"/> pain with intercourse     |
| <input type="checkbox"/> breast pain           | <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> vaginal itching/burning   |
| <input type="checkbox"/> missed periods        | <input type="checkbox"/> heavy periods     | <input type="checkbox"/> spotting between periods  |
| <input type="checkbox"/> lack of sexual desire | <input type="checkbox"/> genital eruptions | <input type="checkbox"/> difficulty having orgasms |

Age of first menses \_\_\_\_\_ Did you have a normal puberty?  Yes  No

Periods occur every \_\_\_\_ days. Regular?  Yes  No Periods usually last \_\_\_\_ days.  
 First day of last period \_\_\_\_\_  
 \_\_\_# of pregnancies \_\_\_# of births \_\_\_# of miscarriages \_\_\_# of abortions  
 Any complications of pregnancy?  Yes  No If yes, please  
 explain. \_\_\_\_\_  
 Are you currently sexually active?  Yes  No Current form of contraception \_\_\_\_\_  
 Have you ever used birth control pills?  Yes  No If yes, how long? \_\_\_\_\_

**Mental/Emotional**

___ depressed mood	___ restlessness	___ mental confusion
___ suicidal thoughts	___ excessive worry	___ mood swings
___ angered easily	___ loneliness	___ frequent crying
___ afraid of being alone	___ critical of others	___ suspicious/jealous
___ shy/timid	___ scary dreams	___ confident/secure

**PAST MEDICAL HISTORY**

Drug and other known allergies: \_\_\_\_\_

List any medications, vitamins, minerals, herbs or other supplements you are presently taking: \_\_\_\_\_

When did you last receive medical care, and for what reason? \_\_\_\_\_

Do you have a history of antibiotic use? \_\_\_\_\_

Do you have a history of any yeast or fungal infections? \_\_\_\_\_

Hospitalizations (reasons why, after effects)	Date
_____	_____
_____	_____
_____	_____

**FAMILY HISTORY**

	Age(if alive)	Age(at death)	Health Problems/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
<u>Maternal</u>			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____
<u>Paternal</u>			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____

What is your nationality? \_\_\_\_\_

**SOCIAL/ENVIRONMENTAL**

List any current health habits (tobacco, alcohol, drugs, etc.) that may be contributing to your current health problem, and for how long.

Do you exercise? (include type and frequency) \_\_\_\_\_

Do you drink caffeinated beverages?  Yes  No How often? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

You currently live with? spouse\_\_ partner\_\_ parents\_\_ friends\_\_ children\_\_ alone\_\_

Are you? married\_\_ separated\_\_ divorced\_\_ widowed\_\_ single\_\_ in a relationship\_\_

How many hours do you sleep nightly?\_\_ Do you wake rested?  Yes  No

Do you have any problems with your sleep? \_\_\_\_\_

Describe your energy level from 1-10 (on the average). \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

Circle any of the following that you have been exposed to in the past. In addition, circle anything you may have a heightened sensitivity to:

- pesticides    mold    dust    mercury (or other metals)    solvents    radiation
- herbicides    toxic fumes or chemicals    second hand smoke    dry cleaning chemicals
- mold    new building or car    other chemicals (please list) \_\_\_\_\_

Please list any other problems or concerns that have not been previously noted. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*THANK YOU FOR YOUR COOPERATION, PATIENCE AND THOROUGHNESS\*\*\*