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Please complete this form and either bring or mail it to the office.

PATIENT INFORMATION:

Name_____ Age _____ Date of Birth _____

Address_____ City _____

State _____ ZIP _____ Email Address _____

Home Phone _____ Fax_____

Cell _____ Work _____

Occupation _____ Number of Children _____

Father's Name_____ Mother's Name _____

Background Information
Please list your main complaints, concerns, questions in order of importance

1) _____

2) _____

3) _____

4) _____

How did you hear about Dr. Lee? _____

_____

Please provide recent (past 12 months) medical records, lab test results, hospital discharge summary and a list of medications and/or supplements currently being taken.

PAST HEALTH HISTORY:

Neonatal: Any problems with your mother's pregnancy, labor or delivery with you? (like illness, stress, smoking, medications, alcohol, etc.) _____ Were you bottle_____ or breast fed_____?
Childhood: Was your home life: (circle all that apply) loving, supportive, stressful, abusive, peaceful, loud, argumentative, educational, alcoholic, friendly, single-parent, lonely?
Additional comments_____
Childhood Illness/Concerns: (Circle all that apply) Colic, Eczema, Asthma, Allergies, Polio, Attentional Deficits, Hyperactivity, Learning Disabilities, Bronchitis, Meningitis, Seizures, Rheumatic Fever, Recurrent Colds, Ear Infections, Bed Wetting, Tonsillectomy, Surgery or Hospitalizations: (describe)_____
Other:_____
Adult Health Problems
Travel: Have you ever traveled outside of the country? _____
If so, where?_____ When?_____
Any parasites?_____ Other illness? _____
Toxic Exposures: Any exposure to pesticides?_____ Herbicides (like agent orange, etc.)? _____ Toxic metals (mercury, aluminum, cadmium, lead, uranium, etc.)?_____
If so, which?_____
Immunizations: (Specify when, if known) Smallpox_____ Last Tetanus_____
Full polio series_____ Mumps (or mumps shot)_____ Measles (or measles shot)_____ Hepatitis A Vaccination_____ Hepatitis B Vaccination_____
Pneumonia Vaccination_____ Diphtheria Vaccination_____ Pertussis (Whooping Cough) Vaccination_____ Other_____

FAMILY HEALTH HISTORY

Is there a **family history** of: (please ***check*** any that apply)
Heart disease?_____ Cancer?_____ Liver disease?_____ Kidney disease?_____ Allergy? _____ Gall Bladder Disease?_____ Ulcer?_____ Irritable bowel?_____ Epilepsy?_____ Depression?_____ Stroke?_____ Mental Illness?_____ Diabetes?_____ Arthritis?_____ Obesity?_____ Asthma?_____ Emphysema?_____ Anemia?_____ Bleeding, bruising?_____ Crohn's Disease/colitis?_____ Alcoholism?_____ Hepatitis?_____ High Blood Pressure? _____ High Cholesterol?_____ Arteriosclerosis?_____ Polio?_____ Other?
_____
List **Family Members** , their ages (or if deceased, their age at death), and any medical problems they have or have had:
Mother:_____ Father:_____
Mother's Mother:_____ Father's Mother:_____
Mother's Father:_____ Father's Father:_____
Siblings:_____ Children:_____
Other relatives (aunts, uncles, cousins):_____
_____
_____
_____
_____

CURRENT HEALTH HISTORY

Check if you regularly eat, drink or use: Candy_____; Sugary foods_____; Carbonated beverages_____; Tea_____; Coffee_____; Caffeinated sodas_____; Cigarettes_____; Other tobacco products_____; Margarine_____; Fried foods_____; Fatty meats_____; Luncheon meats_____; Eat out a lot, especially at fast food restaurants?_____ What foods do you crave?_____

Place a ***check mark*** if you: Diet often?_____; Do you exercise regularly (be honest)? Yes_____ No_____; Are you exposed to chemicals at work or at home?_____; Salt food without tasting it first?_____; Are you exposed to cigarette smoke?_____; Smoke tobacco products?_____; Chew tobacco products?_____; Take (or have taken) "recreational" drugs? _____; If so, which?_____
Do you (or have you) used alcoholic beverages?_____ What kind?_____
How often?_____ When?_____

Stress: Are you under low, moderate or high levels of stress? (circle one)
Do you use any stress reduction or relaxation methods like yoga, prayer, meditation or selfhypnosis?_____
If so, which?_____ How often?_____ Length of Sessions?_____

Sleep: What time do you retire?_____; Arise?_____ Do you awaken during the night? _____ Is your sleep restful?_____ Do you awaken feeling refreshed in the morning? _____ Do you dream?_____ Do you have sleep apnea?_____ Do you snore? _____

Interests: List any hobbies or life interests_____
_____

Medications: List any medications, vitamins, minerals, herbal remedies, etc. that you are currently (or have recently been) taking: (Please continue list on page 8) _____
_____
_____

Are you undergoing radiation therapy? Yes____ No____; Any chemotherapy? Yes_____ No_____ If yes, which?_____

Do you use, or have you ever used, any "recreational" drugs or alcohol? Yes_____ No____
If so, which?_____
How much/how often?_____

Lab Work, Tests & Examinations:
Last Physical Exam_____; X-Rays_____; GI Series_____;
EKG_____; Stress EKG_____; Angiogram or Catheterization_____;
Blood Tests_____; Ultrasound_____ Other_____

INSTRUCTIONS: Circle the number which best describes the intensity/frequency of your symptoms. If you don't know the answer, leave it blank. 0 = symptom absent; 1 = mild or rare symptoms; 2 = moderate; 3 = severe or very frequent symptoms; ? = "I don't know"

PART II: Digestion_ _____

Section A: Symptoms associated with hypo-acidity

1. Burping	0 1 2 3	
2. Prolonged fullness after meals	0 1 2 3	
3. Bloating	0 1 2 3	
4. Poor appetite	0 1 2 3	
5. Stomach gets upset easily	0 1 2 3	
6. History of constipation	0 1 2 3	
7. Known food allergies	0 1 2 3	
8. Lack of interest in eating	0 1 2 3	

Section B: Symptoms of small bowel dysfunction

1. Abdominal cramps	0 1 2 3	
2. Indigestion 1-3 hrs. after a meal	0 1 2 3	
3. Fatigue after eating	0 1 2 3	
4. Lower bowel gas	0 1 2 3	
5. Alternating constipation & diarrhea	0 1 2 3	
6. Diarrhea	0 1 2 3	
7. Roughage causes constipation	0 1 2 3	
8. Mucous in stools	0 1 2 3	
9. Stool poorly formed	0 1 2 3	
10. Shiny stool	0 1 2 3	
11. 3 or more large Bms/day	0 1 2 3	
12. Foul-smelling stool	0 1 2 3	
13. Dry, flaky skin and/or dry brittle hair	0 1 2 3	
14. Pain in left side under rib cage	0 1 2 3	
15. Acne	0 1 2 3	
16. Food allergies	0 1 2 3	
17. Difficulty gaining weight	0 1 2 3	
18. Belching excessively	0 1 2 3	

Section C: Symptoms associated with hyper-acidity

1. Stomach pains	0 1 2 3	
2. Mealtime stomach pains	0 1 2 3	
3. Dependency on antacids	0 1 2 3	
4. Chronic abdominal pain	0 1 2 3	
5. "Butterflies" in stomach	0 1 2 3	
6. Difficulty belching	0 1 2 3	
7. Stomachache when upset	0 1 2 3	
8. Sudden acute indigestion	NO	YES
9. Carbonated drinks relieve symptoms	NO	YES
10. Milk relieves stomach pains	NO	YES
11. History of ulcer or gastritis	NO	YES
12. Current ulcer	NO	YES
13. Black stool (not on iron)	NO	YES

Section D: Symptoms of colon dysfunction

1. Seasonal diarrhea	0 1 2 3	
2. Ulcerative colitis	0 1 2 3	
3. Bladder and kidney infections	0 1 2 3	
4. Vaginal yeast infections	0 1 2 3	
5. Abdominal cramps	0 1 2 3	
6. Toe & fingernail fungus	0 1 2 3	
7. Alternating constipation and diarrhea	0 1 2 3	
8. Constipation	0 1 2 3	
9. Bloating/gassiness	0 1 2 3	
10. History of antibiotic use	NO	YES
11. Diverticulitis	NO	YES
12. Rectal bleeding	NO	YES
13. Crohn's disease	NO	YES
14. Weight loss	NO	YES
15. Anemia	NO	YES
16. Arthritis	NO	YES
17. Kidney stones	NO	YES
18. Irritable Bowel Syndrome	NO	YES
19. Intestinal polyps	NO	YES

PART III: Fat Metabolism

Section A: Liver / Gallbladder

1. Intolerance to greasy foods	0 1 2 3	
2. Headaches after eating	0 1 2 3	
3. Light (tan) colored stool	0 1 2 3	
4. Foul-smelling stool	0 1 2 3	
5. Less than 1 BM per day	0 1 2 3	
6. Constipation	0 1 2 3	
7. Hard stool	0 1 2 3	
8. Sour taste in mouth	0 1 2 3	
9. Grey-colored skin	0 1 2 3	
10. Yellow in whites of eyes	0 1 2 3	
11. Bad breath	0 1 2 3	
12. Body odor	0 1 2 3	
13. Drowsiness after eating	0 1 2 3	
14. Pain under right rib cage	0 1 2 3	
15. Painful to pass stool	0 1 2 3	
16. Retain water	0 1 2 3	
17. Painful big toe / gout	0 1 2 3	
18. Pain along outside of leg	0 1 2 3	
19. Dry skin and/or hair	0 1 2 3	
20. Red blood in stool	NO	YES
21. Jaundice / hepatitis history	NO	YES
22. High blood cholesterol	NO	YES
23. Cholesterol over 300	NO	YES
24. Triglyceride over 115	NO	YES

Section B: Thyroid

1. Bulging eyes	0 1 2 3
2. Strong-smelling urine	0 1 2 3
3. Thick skin and fingernails	0 1 2 3
4. Dry skin	0 1 2 3
5. Sensitive to the cold	0 1 2 3

6. Cold hands and feet 0 1 2 3
7. Excessive menstrual bleeding 0 1 2 3
8. Chronic fatigue 0 1 2 3
9. Trouble waking up in the morning 0 1 2 3
10. Depressed, apathetic 0 1 2 3
11. Low sex drive 0 1 2 3
12. Puffy, wrinkly skin 0 1 2 3
13. Sugar causes irritability and mood swings 0 1 2 3
14. Premenstrual tension 0 1 2 3
15. Constipation 0 1 2 3
16. Muscle pains or stiffness 0 1 2 3
17. Thinning or loss of outside portion of eyebrow NO YES
18. Gain weight easily NO YES
19. Anemia, unaffected by iron NO YES
20. Axillary (armpit) temperature below 97.6° F NO YES
21. Infertility NO YES

PART IV: Adrenal Function

Section A: Hypo-adrenalism

1. Feel tired in the afternoon 0 1 2 3
2. Itchy eyes 0 1 2 3
3. Red or inflamed eyes 0 1 2 3
4. Low blood pressure 0 1 2 3
5. Sensitive to exhaust fumes, smoke, smog, petrochemicals 0 1 2 3
6. Periodic constipation 0 1 2 3
7. Cannot tolerate much exercise 0 1 2 3
8. Depression or rapid mood swings 0 1 2 3
9. Decreased body hair 0 1 2 3
10. Dark circles under eyes 0 1 2 3
11. Dizziness upon standing 0 1 2 3
12. Lack of mental alertness 0 1 2 3
13. Catch colds easily when the weather changes 0 1 2 3
14. Headaches 0 1 2 3
15. Difficulty breathing 0 1 2 3
16. Water retention 0 1 2 3
17. Eyes sensitive to bright light 0 1 2 3
18. Feel weak and shaky at times 0 1 2 3

PART V : Musculo-skeletal

Section A: Bone Integrity

1. Pain in fingers 0 1 2 3
2. Bones sore / painful 0 1 2 3
3. Eat meat / high protein diet 0 1 2 3
4. Cavities: lifetime history of 0 1 2 3
5. Arthritis 0 1 2 3
6. How many times per week do you drink sodas? 0 1-3 4-7 7+
7. Use antacids? 0 1-3 4-7 7+
8. Gum disease NO YES
9. Bone loss NO YES
10. Calcium deposits NO YES
11. Dentures NO YES

12. Bone deformity NO YES
13. Osteoporosis/osteomalacia NO YES
14. Recent bone fracture NO YES
15. Have had a hysterectomy or are post-menopause NO YES

Section B: Muscle

1. Muscle spasms 0 1 2 3
2. Tightness in shoulder muscles 0 1 2 3
3. Muscle cramps 0 1 2 3
4. Pain in arms / hands 0 1 2 3
5. Leg cramps at night 0 1 2 3
6. Stiff all over 0 1 2 3
7. Stiff on arising in morning 0 1 2 3
8. Difficulty in sitting straight 0 1 2 3
9. Pain in neck or shoulders 0 1 2 3
10. Back pain 0 1 2 3

Section C: Connective tissues

1. Joints over-flex (compared to other people's joints) 0 1 2 3
2. Back pain 0 1 2 3
3. Swollen knees or elbows 0 1 2 3
4. Sprains / strains 0 1 2 3
5. Bursitis 0 1 2 3
6. Varicose Veins 0 1 2 3
7. Tendonitis 0 1 2 3
8. Joint pain 0 1 2 3
9. Slipped disc NO YES
10. Herniated disc NO YES
11. Loss in height NO YES
12. Injure easily NO YES
13. Hemorrhoids NO YES

PART VI: Allergy, Immunology, Metabolism

1. History of "hay fever" or "allergic Rhinitis" 0 1 2 3
2. History of frequent itchy nose, eyes, watery nose, sneezing 0 1 2 3
3. History of asthma, asthmatic bronchitis, episodes of wheezing, trouble breathing 0 1 2 3
4. Frequent cough 0 1 2 3
5. History of eczema 0 1 2 3
6. Drug allergy? NO YES

If "YES" to which drugs are you allergic?

_____

_____

7. History of urticaria (hives) 0 1 2 3
8. Food allergy 0 1 2 3
9. Pollen, dust, mold or dander allergy 0 1 2 3
10. Rub nose or eyes frequently 0 1 2 3
11. Family history of either asthma, hay, fever, hives, other allergy 0 1 2 3
12. Snoring 0 1 2 3
13. Sleep apnea (episodes of not breathing at night) 0 1 2 3
14. Tired during the day 0 1 2 3
15. Puffy, dark circles under eyes 0 1 2 3

16. Sensitive to detergents, paints perfumes, etc. 0 1 2 3

Any history of:
Hospitalizations? NO YES
Surgeries? NO YES
Please list hospitalizations/surgeries (why & when) _____
_____
_____
Any history of **chronic illnesses** (arthritis, lupus, lung disease, heart disease, kidney disease, chronic fatigue, fibromyalgia, mental illness, etc.)? NO YES
If so, which?_____
Any history of **fractures (broken bones)**? NO YES
Please list _____

MOOD DISORDERS
Any history of:

Depression?	NO	YES
Anxiety?	NO	YES
Excessive anger?	NO	YES
Stress?	NO	YES
Emotional problems?	NO	YES
Family problems?	NO	YES
Forgetfulness?	NO	YES
Trouble learning?	NO	YES
Hyperactivity?	NO	YES
Mood swings?	NO	YES
Prolonged grief?	NO	YES
Excessive sleepiness?	NO	YES
Insomnia?	NO	YES
Muscle aches/pains?	NO	YES
Excessive worries	NO	YES
Psychological abuse?	NO	YES
Physical abuse?	NO	YES
Sexual abuse?	NO	YES
Allergies?	NO	YES
	To what?_____	

Women Only:

Menstrual History- Still menstruating?_____; Age of onset?_____; Regular? NO YES; Cycle length in days (start to start)?_____; Duration?_____; Heavy?_____; Medium?_____; Light?_____; Pain or cramps?_____; Mood changes?_____; Water retention with period?_____; PMS?_____; Abnormal pregnancies?_____;

Diabetes with pregnancy?_____; Problems with deliveries?_____; Miscarriages?_____; Number of children?_____; STD's?_____; Bone density measurements?_____ When?_____; Colonoscopies?_____; Do you use birth control?_____; If so, what method and for how long?
_____; Number of pregnancies?_____;

Outcome of pregnancies?_____;
Any infertility problems?_____; Ever breast fed? NO YES; Any history of breast lumps?_____; Any breast operations?_____; Any mammograms?_____ Most recent_____

Are you in menopause now?_____; Any symptoms (hot flashes, etc.)?_____; Any history of endometriosis, fibroids, ovarian cysts, breast tenderness?_____; Any pain during intercourse?_____; Frequent urination? _____; Pain on urination?_____.

Men Only:
Any pain on urination?_____; Any problem getting erections?_____; Frequency of urination?
_____

Problem maintaining erections?_____; Any problems with ejaculation?_____; Any problem with curvature to penis?_____ Nighttime urination?_____ If so, how many times?_____; Decreased force of urination?_____ Dribbling after urination ceases?_____ Any prostate enlargement?_____
Any prostate cancer?_____ Any prostate surgery or biopsies?_____ If you know your PSA (last one) please list it here_____; Bone density check?_____; Colonoscopy?_____; Any history of STDs?_____

Explain or expand on any of the above if you wish:_____
_____

NUTRIENT SUPPLEMENTS

If you are taking vitamins, minerals, herbal remedies or other supplements please list them below.
Tell us the dosages of each substance and how often you take them.

PRESCRIPTION MEDICATIONS *List these also with dosages and frequencies*
