

# THE LEE CLINIC

## William Lee, M.D.

6 Wirt St NW, Leesburg, VA 20175 - (703) 777-6672  
 2228 Papermill Rd, Suite I, Winchester, Va. 22601 - (540) 542-1700

### Your Personal Profile (please print)

|            |                      |                |                      |         |   |
|------------|----------------------|----------------|----------------------|---------|---|
| Last Name  | <input type="text"/> | Date of Birth  | <input type="text"/> | E-Mail  | <input type="text"/>  |
| First Name | <input type="text"/> | Age            | <input type="text"/> | Race    | <input type="text"/>  |
| Address    | <input type="text"/> | SSN            | <input type="text"/> | Height  | <input type="text"/>  |
| City       | <input type="text"/> | Home Phone     | <input type="text"/> | Weight  | <input type="text"/>  |
| State      | <input type="text"/> | Business Phone | <input type="text"/> | Adopted | Yes <input type="checkbox"/> No <input type="checkbox"/>      |
| Zip Code   | <input type="text"/> | Mobile Phone   | <input type="text"/> | Sex     | Male <input type="checkbox"/> Female <input type="checkbox"/> |

### Medical Provider:

### How did you learn about The Lee Clinic?

### The reason I am seeking care and treatment at The Lee Clinic:

### Your Medical Profile (Check boxes if applicable)

| History                | Self                     | Grand Parent             | Father                   | Mother                   | Brother Sister           | Uncle Aunt               |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Breast Cancer          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uterine Cancer         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ovarian Cancer         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate Cancer        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blocked Arteries       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pancreatic Cancer      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Cancer         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Cancers          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alzheimer's Disease    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parkinson's Disease    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Short Term Memory Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Your Lifestyle Profile

(Enter number or yes/no)

|                                   |  |
|-----------------------------------|--|
| Do you smoke?                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you use smokeless tobacco?     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Aerobic exercise (hours per week) | <input type="text"/>                                     |
| Weight training (hours per week)  | <input type="text"/>                                     |
| Do you feel severe stress?        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you experience mood swings?    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Are you fatigued?                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you take an aspirin daily?     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you have a low sex drive?      | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Are you currently on hormone therapy? Yes  No

If yes please list:

| Hormone | Dosage | Patch Pill, Cream | Frequency of use |
|---------|--------|-------------------|------------------|
|         |        |                   |                  |
|         |        |                   |                  |

## Food Profile Section

Your Name \_\_\_\_\_

| Food               | Serving      | Servings Per Week    |
|--------------------|--------------|----------------------|
| Alcohol            | 1 oz.        | <input type="text"/> |
| Doughnuts/Pastry   | 1            | <input type="text"/> |
| Bagels             | 1            | <input type="text"/> |
| Candy              | 1 piece      | <input type="text"/> |
| Bread/Roll         | 1 slice/roll | <input type="text"/> |
| White Rice         | 1 cup        | <input type="text"/> |
| Pasta              | 1 cup        | <input type="text"/> |
| White Potato       | 1            | <input type="text"/> |
| White Bread        | 1 slice      | <input type="text"/> |
| Brown Rice         | 1 cup        | <input type="text"/> |
| Sweet Potato       | 1            | <input type="text"/> |
| Salad              | 1 bowl       | <input type="text"/> |
| Hamburger          | 1/4 lb.      | <input type="text"/> |
| Whole Grain Bread  | 1 slice      | <input type="text"/> |
| Tuna Fish          | 1 can        | <input type="text"/> |
| Salmon             | 6 oz.        | <input type="text"/> |
| Skim Milk          | 6 oz.        | <input type="text"/> |
| Lean Beef          | 6 oz.        | <input type="text"/> |
| Chicken White Meat | 6 oz.        | <input type="text"/> |
| Carrots            | 1 cup        | <input type="text"/> |

| Food                   | Serving   | Servings Per Week    |
|------------------------|-----------|----------------------|
| Cheese                 | 1 oz.     | <input type="text"/> |
| Sodas                  | 12 oz.    | <input type="text"/> |
| Cookies                | 1         | <input type="text"/> |
| Cake                   | 1 piece   | <input type="text"/> |
| Jelly/Jams             | 1 oz.     | <input type="text"/> |
| Potato Chips           | Small bag | <input type="text"/> |
| French Fries           | Small     | <input type="text"/> |
| Whole Milk             | 1 cup     | <input type="text"/> |
| Fruit Juice            | 6 oz.     | <input type="text"/> |
| Beans/Legumes          | 1 cup     | <input type="text"/> |
| Banana                 | 1         | <input type="text"/> |
| Apple                  | 1         | <input type="text"/> |
| Fresh Fruit, other     | 1 piece   | <input type="text"/> |
| Pretzels               | Small bag | <input type="text"/> |
| Oatmeal                | 1 bowl    | <input type="text"/> |
| Vegetables             | 1 cup     | <input type="text"/> |
| Non Fat Cottage Cheese | 6 oz.     | <input type="text"/> |
| Eggs                   | 1         | <input type="text"/> |
| Soy Protein            | 6 oz.     | <input type="text"/> |
| Nuts                   | 3 oz.     | <input type="text"/> |

## Your Personality Profile (Check appropriate boxes)

| Lifestyle Habit  | Seldom                   | Sometimes                | Often                    |
|--|--------------------------|--------------------------|--------------------------|
| 1. Do you have to do everything yourself?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Can you relax daily?                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you get mad at people close to you?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you think of yourself as a religious/spiritual person? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you eat when stressed?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. How often do you laugh?                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do things have to be done in a certain way?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you think that family is most important?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you get mad with co-workers?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you get angry waiting in line?                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get mad in traffic?                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is the day too short to do everything?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you wake up thinking of things you have to do?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are finances a problem?                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you a stickler for details?                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have trouble delegating to others?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### MEN:

#### PLEASE COMPLETE THIS SECTION

Date of last PSA: \_\_\_\_\_

Date of last Prostate Exam: \_\_\_\_\_

### WOMEN:

#### PLEASE COMPLETE THIS SECTION

Menstruating

Irregular Menstruation

Menopausal

1st Date of last period: \_\_\_\_\_

Hysterectomy Date: \_\_\_\_\_  
(if applicable)

Ovaries Removed: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_

Date of last Mammogram: \_\_\_\_\_

Past hormone use: \_\_\_\_\_

**Past Illnesses, Surgeries, Traumas and Accidents (Diabetes, High Blood Pressure, etc.) (Explain)**

|   |  |
|---|--|
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |
| 7 |  |
| 8 |  |

**Your Allergies (Explain)**

|   |                       |
|---|-----------------------|
| 1 | <b>Medication:</b>    |
| 2 | <b>Food:</b>          |
| 3 | <b>Environmental:</b> |
| 4 | <b>Other:</b>         |

**Your Current Medications (List)**

|   | <b><u>Name</u></b> | <b><u>Dose Per Day</u></b> |
|---|--------------------|----------------------------|
| 1 |                    |                            |
| 2 |                    |                            |
| 3 |                    |                            |
| 4 |                    |                            |
| 5 |                    |                            |

**Your Current Nutritional Supplements and/or Herbs (List)**

|   | <b><u>Name</u></b> | <b><u>Dose Per Day</u></b> |
|---|--------------------|----------------------------|
| 1 |                    |                            |
| 2 |                    |                            |
| 3 |                    |                            |
| 4 |                    |                            |
| 5 |                    |                            |

Put a number from 1 - 10 with 10 being the worst symptom. Leave blank if it doesn't apply.

1. Estrogens low

|                     |  |
|---------------------|--|
| Hot flashes         |  |
| Night sweats        |  |
| Vaginal dryness     |  |
| Foggy thinking      |  |
| Scanty or no menses |  |
| Depressed           |  |
| Bone loss           |  |
| Tearful             |  |
| Memory lapse        |  |
| Hair loss           |  |

2. Estrogens high

|                                       |  |
|---------------------------------------|--|
| Breast tenderness (Female)            |  |
| Fibrosis (Female)                     |  |
| PMS (Female)                          |  |
| Endometriosis (Female)                |  |
| Heavy periods (Female)                |  |
| Fibrocystic breasts (Female)          |  |
| Large breasts (Female)                |  |
| Heavy hips or abdomen                 |  |
| Water retention                       |  |
| Breast or prostate enlargement (Male) |  |

3. Progesterone low

|                    |  |
|--------------------|--|
| PMS                |  |
| Miscarriages       |  |
| Irregular periods  |  |
| Heavy periods      |  |
| Clots with periods |  |
| Breast tenderness  |  |
| Bone loss          |  |
| Irritable          |  |
| Insomnia           |  |
| Migraines          |  |
| Fibroids           |  |
| Infertile          |  |
| Endometriosis      |  |

4. Progesterone high (women only)

|              |  |
|--------------|--|
| Sleepy       |  |
| Dizzy        |  |
| Night sweats |  |

5. Testosterone/DHEA low

|                                   |  |
|-----------------------------------|--|
| Low sex drive                     |  |
| Weak muscles                      |  |
| Low energy                        |  |
| Bone loss                         |  |
| Joint aches and pains             |  |
| Muscular atrophy                  |  |
| Masculine hair loss pattern       |  |
| Reduced sexual performance (male) |  |

6. Testosterone/DHEA high

|                                |  |
|--------------------------------|--|
| Strong morning erections (Men) |  |
| High sex drive                 |  |
| Strong muscles                 |  |
| High energy                    |  |
| Masculine hair pattern         |  |
| Good mental power              |  |
| Good physical stamina          |  |
| Acne                           |  |
| Nightmares                     |  |
| Facial hair (Women)            |  |
| Sore nipples (Women)           |  |

### 7. Thyroid low

|                          |  |
|--------------------------|--|
| Low body temperature     |  |
| Slow or foggy thinking   |  |
| Loss of lateral eyebrows |  |
| Sensitive to cold        |  |
| Puffy around eyes, chin  |  |
| Gain weight easily       |  |
| Needs a lot of sleep     |  |
| Depressed                |  |
| Tired during the day     |  |
| Head hair loss           |  |
| Goiter                   |  |
| Fertility problems       |  |
| Constipation             |  |

### 9. Adrenals low

|                                    |  |
|------------------------------------|--|
| Startles easily                    |  |
| Low emotional reserve              |  |
| Low blood pressure                 |  |
| Can't tolerate hot or cold weather |  |
| Many allergies                     |  |
| Fatigue, get tired quickly         |  |
| Get dizzy when standing            |  |
| Sensitive to bright light          |  |
| Crave caffeine                     |  |
| Leg and pubic hair loss            |  |
| Low blood sugar                    |  |
| Fear and anxiety                   |  |
| Pale around mouth                  |  |
| Urgent need for sugar              |  |

### 11. Insulin high

|                                     |  |
|-------------------------------------|--|
| Apple shape                         |  |
| Gain weight easily                  |  |
| Shaky or hungry 2 hours after meals |  |
| Rapid aging                         |  |
| High or low blood sugar             |  |
| Often hungry                        |  |
| Craves sugars, starches             |  |

### 8. Thyroid high

|  |  |
|--|--|
| Nervous                                |  |
| Fast pulse                             |  |
| Loose stools                           |  |
| Intolerance to heat                    |  |
| Tremor                                 |  |
| Bulging eyes                           |  |
| Can't gain weight                      |  |
| Highly emotional                       |  |
| Palpitations                           |  |
| Increased appetite without weight gain |  |

### 10. Adrenals high

|  |  |
|--|--|
| Sleep disturbed                          |  |
| Gain weight easily                       |  |
| Apple shaped                             |  |
| Sleep disturbances                       |  |
| Sugar craving                            |  |
| Anxious                                  |  |
| Depressed                                |  |
| High blood pressure                      |  |
| Hair growth on face or body (Women only) |  |
| Thick eyebrows                           |  |

### 12. Liver stress

|                                 |  |
|---------------------------------|--|
| Night sweats                    |  |
| Chemical sensitivity            |  |
| Red palms                       |  |
| Gall bladder problems           |  |
| Allergies                       |  |
| Exposure to toxins              |  |
| Brown spots on skin             |  |
| Burning feet                    |  |
| Bitter, metallic taste in mouth |  |
| Nausea in the morning           |  |
| Swelling legs                   |  |
| Hemorrhoids                     |  |