**Dr. Steven L. Benedict, L.Ac., O.M.D.**
**Acupuncture and Oriental Medicine**
**Integrative Medicine, Nutrition**
**12340 Santa Monica Boulevard, Suite 300**
**Los Angeles, CA 90025**
**Phone: 310-442-7697, Fax: 310-442-7698**

Dear

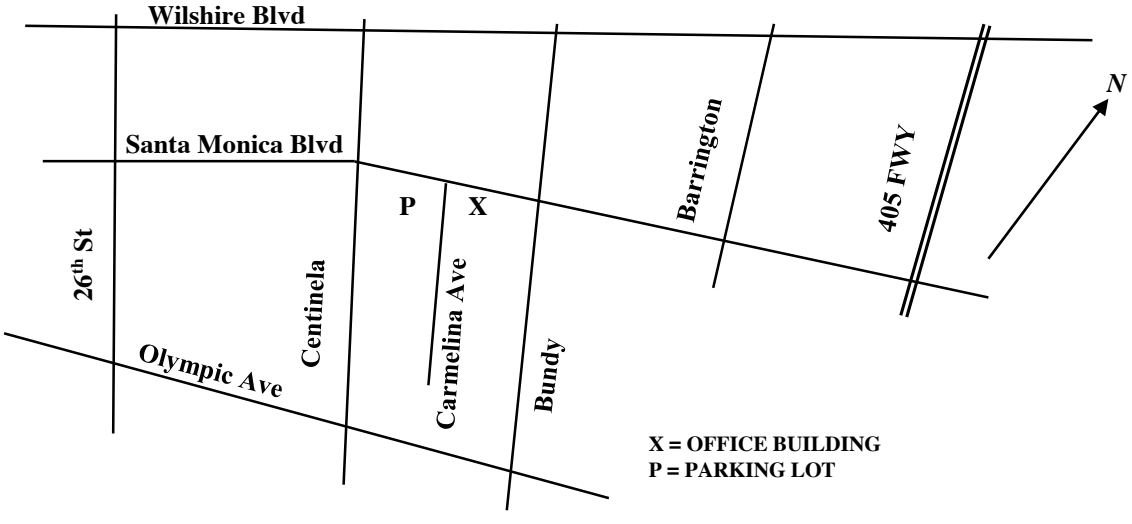
Thank you for making an appointment to see me for your health care services. Please complete the attached health questionnaire and either return it in advance of your appointment by email or bring it with you when you come for your appointment. Your appointment has been scheduled for:

My office is located at the southeast corner of Santa Monica Boulevard and Carmelina Avenue. (Carmelina is 3 blocks west of Bundy.) Ample street parking is available. In addition, three parking spaces (#19 and #15A/B) are reserved for your use in the parking lot located on the west side of Carmelina Avenue. (The entrance to this lot has two signs that say "We tow immediately.") Enter the building from either Santa Monica Boulevard (take the elevator to the third floor and turn right) or from Carmelina Avenue (take the stairwell to the third floor and turn right). My office is located in suite 300.

I look forward to seeing you!

Sincerely,

Dr. Steven L. Benedict, L.Ac., O.M.D.
Licensed Acupuncturist
Doctor of Oriental Medicine



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Please complete this health questionnaire before having your initial appointment.

Name _____ Date _____ Soc. Sec. # (Optional) _____

Address _____ City _____ State _____ Zip _____

Male/ female _____ Date of birth _____ Age _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Height: _____ Weight: _____

Number of children _____ Children's age's _____ Occupation _____

Referred by _____ Religion _____

Phone: (home) _____ (business) _____ (other) _____

Email: _____

**MEDICAL HISTORY**

1. Check ( ✔ ) any of the following that apply:

| | Alcoholism | Arthritis | Cancer | Dementia | Depression | Diabetes | Epilepsy | Glaucoma | Heart trouble | Hepatitis | Hypertension | Kidney trouble | Osteoporosis | Stomach Ulcer | Stroke | Thyroid + / - | Tuberculosis | Other | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **YOU** | | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | | | | |
| Brothers | | | | | | | | | | | | | | | | | | | |
| Sisters | | | | | | | | | | | | | | | | | | | |
| Spouse | | | | | | | | | | | | | | | | | | | |
| Children | | | | | | | | | | | | | | | | | | | |
| Maternal Grandparents | | | | | | | | | | | | | | | | | | | |
| Paternal Grandparents | | | | | | | | | | | | | | | | | | | |

2. Check ( ✔ ) any of the following that you have had:

___ anemia ___ eye disease ___ gall stones ___ gout ___ polio ___ eczema ___ hemorrhoids ___ liver disease

___ chicken pox ___ rheumatic fever ___ bronchitis ___ shingles ___ malaria ___ measles ___ migraine headache

___ diverticulitis ___ hernia ___ neuralgia ___ mononucleosis ___ emphysema ___ pancreatitis ___ mumps ___ jaundice

3. Have you ever been hospitalized? Yes ____ No ____ If so, when and why? _____

4. Check any of the following that you have had and approximately when:

| (✔) | (Year) | Tests and Procedures | (✔) | (Year) | Immunizations |
|---|---|---|---|---|---|
| ____ | _____ | blood testing | ____ | _____ | chickenpox |
| ____ | _____ | bone density scan | ____ | _____ | flu |
| ____ | _____ | colonoscopy | ____ | _____ | hepatitis |
| ____ | _____ | complete physical exam | ____ | _____ | polio |
| ____ | _____ | electrocardiogram (EKG) | ____ | _____ | shingles |
| ____ | _____ | mammogram (women) | ____ | _____ | tetanus |
| ____ | _____ | pap smear (women) | ____ | _____ | measles |
| ____ | _____ | prostate exam (men) | ____ | _____ | mumps |
| ____ | _____ | X-Ray or MRI | ____ | _____ | other |

5. List any known allergies you have to foods, drugs, and other substances: _____

6. Are you currently being treated by someone else? Yes ____ No ____ If so, why? _____

7. Have you previously been treated with acupuncture and Oriental Medicine? Yes ____ No ____ If so, why? _____

8. List any medications which you currently take: _____

_____

9. List any nutritional supplements and herbs which you currently take: _____

_____

_____

10. Past Major illnesses, injuries, accidents, and surgeries: Date or Age

_____ _____

_____ _____

_____ _____

_____ _____

11. Have you ever taken:

| | | | |
|---|---|---|---|
| Birth control pills | _____ | Cortisone/Prednisone | _____ |
| Estrogen | _____ | Thyroid medication | _____ |
| Progesterone | _____ | Allergy shots | _____ |
| Testosterone | _____ | Antibiotics | _____ |

12. Do you wear contacts? _____ Dentures? _____ Pacemaker? _____

13. Have you ever had a tissue mineral or hair mineral analysis? _____ If so, when? _____

14. Have you ever smoked cigarettes or cigars? _____ If so, for how long? _____

15. Do you currently smoke? _____ What brand and how many per day? _____ Do you want to quit? _____

16. Do you drink caffeine beverages? _____ If so, what do you drink, and how often? _____

17. Do you drink alcohol? _____ If so, how often? _____ Type: _____

18. How much water do you drink per day? _____

**LIFESTYLE**

How many hours per week do you spend outside? _____ Do you usually wear sunglasses when you are outside? _____

How many hours per week do you watch T.V.? _____ How many hours per week do you work at a computer? _____

How often do you exercise? _____ What forms of exercise do you enjoy? _____

What hobbies do you enjoy?_____

How often do you take vacations? For how long? _____

**DIET SURVEY**

1. What do you usually eat for breakfast? _____

_____ When do you eat breakfast? _____

2. For lunch?_____

_____ When do you eat lunch? _____

3. For dinner?_____

_____ When do you eat dinner? _____

4. Circle any of the following which you regularly crave: sweet, sour, bitter, salty, spicy, hot temps, cold temps.

**SYMPTOMS REVIEW**

Directions: Circle any of the following symptoms that have bothered you in the past 6 months. Please make any additional comments in the space provided to the right.

| SYMPTOMS | | COMMENTS |
|---|---|---|
| **Head:** | | |
| Headaches | Sore scalp/dandruff | |
| Dizziness | Hair loss | |
| **Eyes:** | | |
| Dry eyes | Excessive tearing | |
| Red eyes | Double vision | |
| Blurred vision | Other vision problems | |
| **Ears:** | | |
| Poor hearing | Ear ringing | |
| Earaches | Deafness | |
| Ear discharge | Other ear problems | |
| **Nose:** | | |
| Poor sense of smell or taste | Frequent colds | |
| Nasal obstruction | Sinus pain | |
| Frequent nose bleeds | Post-nasal drip | |
| **Mouth:** | | |
| Bleeding gums | Ulcers | |
| Sore tongue | Herpes sores | |
| Dry lips | Dry mouth | |
| Dental pain | Other dental problems | |
| **Throat:** | | |
| Sore throats | Difficulty swallowing | |
| Tonsillitis | Spitting up mucus often | |
| Hoarseness | | |
| **Respiratory:** | | |
| Cough | Bloody sputum | |
| Thick sputum | Pain with breathing | |
| Wheezing | Shortness of breath | |

**SYMPTOMS** **COMMENTS**

**Heart:**

Chest pain or pressure
Heart palpitations (flutters)
Difficulty lying flat
Ankle swelling
Exercise intolerance

**Blood:**

Bruise or bleed easily
Cold extremities

**Skin:**

Rash
Dryness
Itching
Pigment changes
Changing moles or lumps
Acne

**Stomach:**

Poor appetite
Excessive appetite
Poor digestion
Heartburn
Vomiting
Food allergies
Pain with eating
Intestinal gas
Nausea
Belching
Sleepy after eating
Ulcers

**Intestines:**

Diarrhea
Constipation
Hemorrhoids
Hernia
Mucus in stool
Abnormal stool color
Dry or hard stool
Loose or watery stool
Undigested food in stool
Blood in stool
Stool painful to pass
Use laxatives often

**How often do you have bowel movements? _____

**Urinary:**

Frequent urination
Frequent bladder infections
Pain or burning with urination
Change in quantity of urine
Hesitancy with urination
Loss of force of urine stream
Need to urinate at night
Dribbling after urination
Urination with cough or sneeze
**How often do you urinate each day? _____

**SYMPTOMS** **COMMENTS**

**Reproduction:**

Decreased sexual desire Excessive sexual desire

Sexually transmitted disease:

____ genital herpes ____ chlamydia ____ gardnerella ____ syphilis ____ gonorrhea

____ genital warts (HPV) ____ trichomonas ____ AIDS ____ Other

Frequency of intercourse: _____

Method of contraception: _____

**Are you or your partner trying to become pregnant? _____

**Men:**

Premature ejaculation Discharge from penis

Nocturnal emission Low sperm count

Prostate problems Difficulty getting or keeping erection

Difficulty impregnating Pain or coldness in genitals

**Women:**

Vaginal pain Vaginal discharge

Vaginal dryness Vaginal bumps or sores

Vaginal itching Painful intercourse

Breast pain Discharge from nipples

Breast lumps Difficulty getting pregnant

**Menses:**

No menstrual period Premenstrual emotional swings

Irregular periods Premenstrual bloating/swelling

Menstrual cramps/pain Heavy blood flow

Spotting between periods Light blood flow

**Date or age your periods began? _____ Are you or might you be pregnant? _____

**Date of your last period? _____ Number of pregnancies? _____

**How many days apart are your periods? _____ Number of abortions? _____

**Length of your period? _____ Number of miscarriages? _____

**Endocrine:**

Neck enlargement

Hair or nail changes

Intolerance to heat or cold

Hot flashes/abnormal sweating

Constant thirst

**SYMPTOMS** **COMMENTS**

**Neurological:**

| | |
|---|---|
| Nervousness | Numbness or tingling in hands/feet |
| Tremors or shaking | Convulsions |
| Incoordination | Paralysis |
| Drowsiness | Memory changes |
| Nerve pain (neuralgia) | Difficulty concentrating |

**Musculoskeletal:**

| | |
|---|---|
| Joint pain | Muscle weakness |
| Joint swelling | Muscle cramps |
| Deformity | Back stiffness/pain |
| TMJ pain | Neck stiffness/pain |

**Sleep:**

| | |
|---|---|
| Insomnia | Wake up often at night |
| Hard to fall asleep | Wake up tired |
| Nightmares | Other sleep problems |

**What time do you go to bed? _____

**Number of hours of sleep per night? _____

**Emotional Health:**

| | |
|---|---|
| Frequent stress | Often feel irritable |
| Mood swings | Often feel happy |
| Often feel angry | Often feel guilty |
| Often feel lonely | Often feel sad or depressed |
| Often overwork | Often feel anxious |

**Job Related:**

| | |
|---|---|
| Excessive stress at work | Feel bored at work |
| Frustrated at work | Want to change jobs |

**Total number of hours you spend driving per week? _____

**Total number of hours you spend working per week? _____

**General:**

| | |
|---|---|
| Abnormal weight gain | Unexplained fever or chills |
| Abnormal weight loss | Loss of feeling of well being |
| Fatigue | Overweight/ underweight |

**Dental history:**

1. Do you currently need dental work? _____ If so, what? _____
2. Number of fillings? _____ Type? (silver, gold, composite, etc.) _____
3. Number of teeth pulled: _____ Number of root canals: _____ Do you wear dentures or partials? _____
4. Do you currently have tooth pain? _____ If so, where? _____
5. Do you have jaw joint pain? _____
6. Do you grind your teeth at night? _____
7. Do you wear a bite appliance at night? _____

**Scars:**

Do you have any major scars anywhere on your body? _____ If so, where? _____

_____

Please list what concerns you the most about your health and well being:

1.

2.

3.

4.

5.

6.

7.

8.

*Thank you for completing this health questionnaire.*

## CANCELLATION POLICY

I understand that occasionally circumstances can arise which might make you unable to attend a scheduled appointment. To prevent any late cancellation charge to you, I ask that you please give me 24 hours notice of any cancellation, at which time I will be happy to reschedule your appointment. If less that 24 hours notice is given, you will be charged the full amount of the missed appointment.

Thank you in advance for your cooperation.

Sincerely,

Dr. Steven L. Benedict, L.Ac., O.M.D.
Licensed Acupuncturist
Doctor of Oriental Medicine

I have read and understand the cancellation policy above.

_____ _____

(Name) (Date)