Dr. Steven L. Benedict, L.Ac., O.M.D.
EastWestHealth.org
Acupuncture and Oriental Medicine
Integrative Functional Medicine, Nutrition
11901 Santa Monica Boulevard, Suite 545
Los Angeles, CA 90025
Phone: 310-442-7697

Dear _____,

Thank you for scheduling your health consultation appointment. I look forward to supporting you to achieve your optimal health! Please complete the attached Health Questionnaire and return it to me (either by mail or email) in advance of your appointment. Please also send me any recent lab test results or other information which you would like to discuss during your consultation.

Your appointment is scheduled for: _____.

I will call you at the numbers listed on your Questionnaire. If you have a preferred number for me to call, please circle that on your Questionnaire.

I look forward to talking with you soon!

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

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Please complete the following 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 ____ HIV or 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

Women - Menses:

No menstrual period Pre-menstrual emotional swings

Irregular periods Pre-menstrual 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 at this time:

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.

I have read and agree to the cancellation policy above.

_____ _____

(Name) (Date)