



Mossop Acupuncture
268 Woodlawn Ave., Albany NY, 12202
mossopacupuncture@gmail.com
(518) 859-3697

Confidential Patient Health History Questionnaire

Today's Date _____
Name _____
Best Phone Number to Reach You _____
Address _____
City _____ State _____ Zip Code _____
Email _____
Age _____ Date of Birth _____ Birthplace _____
Height _____ Weight _____
Marital/Partnership Status _____
Profession/Occupation _____
Family Physician _____ Referred By _____
Emergency Contact _____ Phone _____
Relationship to Patient _____

Have You Been Treated By Acupuncture or East Asian Medicine Before? Yes No

Main Problem(s) you would like help with: _____

How long ago did this problem begin (be specific)? _____



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To what extent does this problem interfere with your daily activities (work, sleep, etc)? _____

Have you been given a diagnosis for this problem: If so, what? _____

What kinds of treatment have you tried? _____

Past Medical History (please include date)

Cancer _____ Diabetes _____ Hepatitis _____

Blood Pressure High/Low _____ / _____ Rheumatic Fever _____

Thyroid Disease _____ Seizures _____ STDs _____

HIV/AIDS _____ Other _____

Surgeries (type of, and date) _____

Significant Trauma (auto accidents, falls, etc) _____

Significant Dental Work (type and date) _____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History (check): Diabetes Cancer High Blood Pressure

Heart Disease Stroke Seizures Asthma Allergies

Other _____



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Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement

Reason for Taking It

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Occupational Stress (physical, chemical, psychological, etc) _____

Do you have a regular exercise program? Yes No Please Describe _____

Have you ever been on a restricted diet? Yes No What Kind? _____

Are you a smoker? Yes No Quit

If so, how many packs of cigarettes do you smoke per day? _____ /day

How many caffeinated beverages (coffee, cola, energy drinks) do you drink per day? _____ /day

How much alcohol do you drink per week? _____ /week

Please describe any use of recreational drugs _____



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Please note the severity of your main problem now:

No Problem Worst Imaginable

Please note the severity of your main problem within the last week:

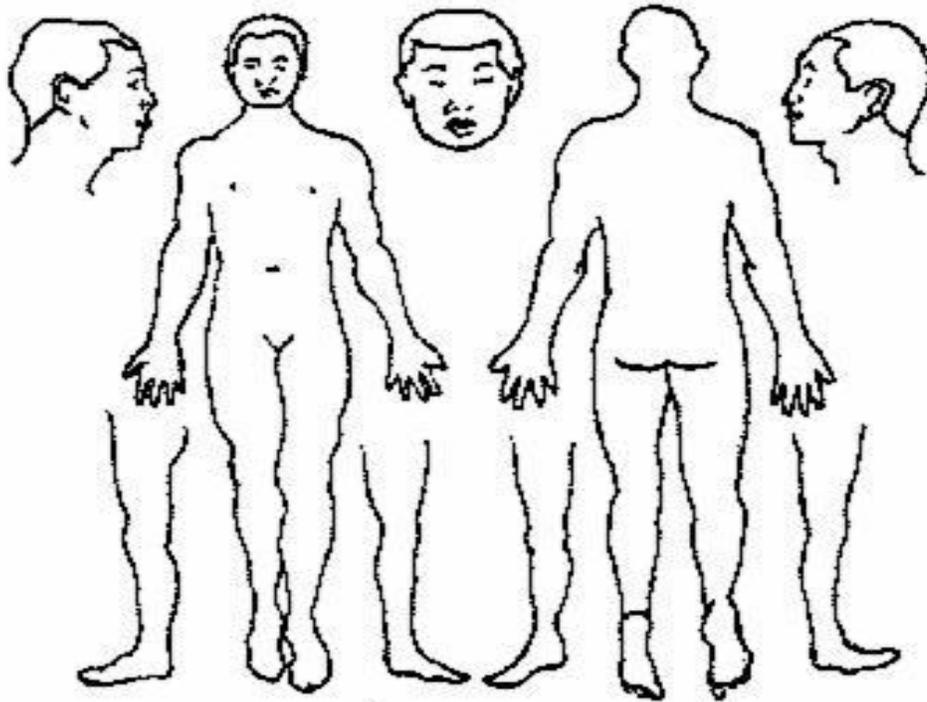
No Problem Worst Imaginable

Comments (please mention any other problems or concerns you would like to discuss)



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Indicate painful or distressed areas



Please check any problems you have had in the last three months:

General

- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- No desire to drink
- Sudden energy drop
- When? _____
- Poor sleep
- Chills
- Tremors

- Poor balance
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations

- Eczema
 - Loss of Hair
 - Hives
 - Pimples
 - Recent moles
 - Warts
 - Other hair or skin problems
-
-

Musculoskeletal

- Muscle pain
- Muscle weakness
- Neck pain

- Shoulder pain
- Hand/wrist pain
- Back pain
- Hip pain
- Knee pain
- Foot/ankle pain

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Swelling of feet
- Phlebitis
- Chest pain
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems _____

Head, Eyes, Ears, Nose, & Throat

- Dizziness
- Poor vision
- Cataracts
- Eye strain
- Night blindness
- Blurry vision
- Spots in front of eyes
- Eye pain
- Color blindness
- Earaches
- Ringing in ears (tinnitus)
- Poor hearing
- Sinus problems
- Grinding teeth
- Teeth problems
- Jaw clicks
- Facial pain
- Nose bleeds

- Recurrent sore throats
- Sores on lips or tongue
- Concussions
- Migraines
- Headaches - where and when _____

- Other head or neck problems _____

Respiratory

- Cough
- Bronchitis
- Pneumonia
- Asthma
- Tuberculosis
- Pain with a deep breath
- Difficulty in breathing when lying down
- Production of phlegm what color _____
- Coughing blood
- Other lung problems _____

- Approximately when was your last cold or flu? _____

Gastrointestinal

- Nausea
- Constipation
- Diarrhea
- Chronic laxative use
- Bad breath
- Belching
- Burning sensation
- Abdominal pain or cramps
- Vomiting
- Gas
- Indigestion
- Blood in stools
- Black stools
- Rectal pain

- Rectal burning
- Anal Prolapse
- Hemorrhoids
- Other stomach / intestinal problems _____

Pregnancy and Gynecology

- Number of pregnancies _____
- Number of births _____
- Premature births _____
- Miscarriages _____
- Abortions _____
- Age at first menses _____
- Days between menses _____
- Duration _____
- First day of last menses _____

- Unusual character (heavy or light)
- Painful periods
- Vaginal discharge What color? _____

- Changes in body/psyche prior to menstruation

- Clots
- Vaginal sores
- Irregular periods
- Last Pap _____

- Breast lumps
- Fibroid Cysts

- Are you sexually active? ___
- Do you practice birth control? Yes No N/A What type and for how long? _____

- Other Gynecology related concerns _____

Genito-urinary

- Pain on urination
- Urgency to urinate

- Frequent urination
 - Unable to hold urine
 - Urinary difficulty
 - Impotency
 - Blood in urine
 - Kidney stones
 - Sores on genitals
 - Other genital or urinary system problems _____
- _____
- Do you wake up to urinate?
 - Yes No
- How often? _____

Any particular color to your urine? _____

Neuropsychological

- Seizures
- Stroke
- Tremors
- Fainting spells
- Areas of numbness
- Concussion
- Poor memory
- Dizziness
- Vertigo

- Loss of balance
 - Lack of coordination
 - Depression
 - Easily stressed
 - Bad temper
 - Anxiety
 - Difficulty concentrating
 - Other neurological or psychological concerns
- _____
- _____

Signature: _____

Date: _____