



Medical Symptoms Questionnaire

Name _____

Date _____

Rate each of the following symptoms based upon your typical health profile for:

Past 30 days

Past 48 hours

Point Scale

0 - *Never or almost never* have the symptom

1 - *Occasionally* have it, effect is *not severe*

2 - *Occasionally* have it, effect is *severe*

3 - *Frequently* have it, effect is *not severe*

4 - *Frequently* have it, effect is *severe*

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision

(does not include near or far-sightedness) Total _____

EARS

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums, lips

_____ Canker sores

Total _____

SKIN

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

Total _____

Medical Symptoms Questionnaire

LUNGS _____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing Total _____

DIGESTIVE TRACT _____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloating feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain Total _____

JOINTS/MUSCLE _____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness Total _____

WEIGHT _____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight Total _____

ENERGY/ACTIVITY _____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness Total _____

MIND _____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities Total _____

EMOTIONS _____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression Total _____

OTHER _____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total _____

GRAND TOTAL TOTAL _____