

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 _____

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 _____