

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 _____