Medical Symptoms Questionnaire

Patient Name_____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days
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-sighted)

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, or 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
_____ Bloated 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 Condition
_____ 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 _____