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 ________

Category	Score	Symptom	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 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* _________