

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 _____