

Medical Symptoms Questionnaire

Patient Name _____ **Date** _____ **Week** _____

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 _____

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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 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	_____		

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