

MEDICAL SYMPTOM QUESTIONNAIRE

Patient Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale 0 – *Never or almost never* have the symptom 3 – *Frequently* have it, effect is *not severe*
1 – *Occasionally* have it, effect is *not severe* 4 – *Frequently* have it, effect is *severe*
2 – *Occasionally* 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 Symptom 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 _____