Print Form

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 0

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 0

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total 0

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation Total 0

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 0

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SKIN

- ☐ Acne
- ☐ Hives, rashes, dry skin
- ☐ Hair loss
- ☐ Flushing, hot flashes
- ☐ Excessive sweating

Total 0

HEART

- ☐ Irregular or skipped heartbeat
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain

Total 0

LUNGS

- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing

Total 0

DIGESTIVE TRACT

- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloated feeling
- ☐ Belching, passing gas
- ☐ Heartburn
- ☐ Intestinal/stomach pain

Total 0

JOINTS/MUSCLE

- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness or limitation of movement
- ☐ Pain or aches in muscles
- ☐ Feeling of weakness or tiredness

Total 0

WEIGHT

- ☐ Binge eating/drinking
- ☐ Craving certain foods
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight

Total 0

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ENERGY/ACTIVITY		Fatigue, sluggishness	
		Apathy, lethargy	
		Hyperactivity	
		Restlessness	Total 0
MIND		Poor memory	
		Confusion, poor comprehension	
		Poor concentration	
		Poor physical coordination	
		Difficulty in making decisions	
		Stuttering or stammering	
		Slurred speech	
		Learning disabilities	Total 0
EMOTIONS		Mood swings	
		Anxiety, fear, nervousness	
		Anger, irritability, aggressiveness	
		Depression	Total 0
OTHER		Frequent illness	
		Frequent or urgent urination	
		Genital itch or discharge	
			Total 0

GRAND TOTAL *TOTAL* 0