



Medical Symptoms Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms, using the below "Point Scale," for the *Past 30 days*.

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

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 _____

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/MUSCLES

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness or limitations of movements
- _____ 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 concentration
- _____ Poor physical coordination
- _____ Difficulty in making decisions
- _____ Stuttering or stammering
- _____ Slurred speech
- _____ Learning disability

Total _____

EMOTIONS

- _____ Mood swings
- _____ Anxiety, fear, nervous
- _____ Anger, irritability, aggressiveness
- _____ Depression

Total _____

OTHER

- _____ Frequent illness
- _____ Frequent or urgent urination
- _____ Genital itch or discharge

Total _____

GRAND TOTAL= _____