

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient's 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 _____

HEART

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

Total _____

- _____ 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_____
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	
	_____	General itching or discharge	Total_____
GRAND TOTAL			TOTAL_____