

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 _____

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 _____