

# 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 \_\_\_\_\_

**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 \_\_\_\_\_

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**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/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 \_\_\_\_\_

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**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 *TOTAL* \_\_\_\_\_