

# Medical Symptoms Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the past **30** days.

- Point Scale*
- 0 - *Never or almost never* have the symptoms
  - 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 \_\_\_\_\_

(PLEASE COMPLETE 2<sup>ND</sup> SIDE OF FORM)

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

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