Medical Symptoms Questionnaire

Name_____Date_____ Initial / Follow-up

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
_____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 ear, hearing loss Total_____

NOSE
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus Total_____

MOUTH/THROAT
_____Chronic coughing
_____Gagging, needing to clear throat
_____Sore throat, hoarseness, loss of voice
_____Stuffy nose
_____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_____

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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 in movement	
	_____Pain or aches in muscles	
	_____Feeling or 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_____

TOTAL_____