

# 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 \_\_\_\_\_

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

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