

Patient Name:

Date:

MEDICAL SYMPTOMS QUESTIONNAIRE

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

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

System	Points	Symptoms	Total
HEAD	0...1...2...3...4	Headaches	
	0...1...2...3...4	Faintness	
	0...1...2...3...4	Dizziness	
	0...1...2...3...4	Insomnia	_____
EYES	0...1...2...3...4	Watery or itchy eyes.	
	0...1...2...3...4	Swollen, reddened, or sticky eyelids	
	0...1...2...3...4	Bags or dark circles under eyes	
	0...1...2...3...4	Blurred or tunnel vision (does not include near- or farsightedness)	_____
EARS	0...1...2...3...4	Itchy ears	
	0...1...2...3...4	Earaches, ear infections	
	0...1...2...3...4	Drainage from ear	
	0...1...2...3...4	Ringing in ears, hearing loss	_____
NOSE	0...1...2...3...4	Stuffy nose	
	0...1...2...3...4	Sinus problems	
	0...1...2...3...4	Hay fever	
	0...1...2...3...4	Sneezing attacks	
	0...1...2...3...4	Excessive mucus formation	_____
MOUTH & THROAT	0...1...2...3...4	Chronic coughing	
	0...1...2...3...4	Gagging, frequent need to clear throat	
	0...1...2...3...4	Sore throat, hoarseness, loss of voice	
	0...1...2...3...4	Swollen or discolored tongue; gums, lips	
	0...1...2...3...4	Canker sores	_____
SKIN	0...1...2...3...4	Acne	
	0...1...2...3...4	Hives, rashes, dry skin	
	0...1...2...3...4	Hair loss	
	0...1...2...3...4	Flushing, hot flashes	
	0...1...2...3...4	Excessive sweating	_____
HEART	0...1...2...3...4	Irregular or skipped heartbeat	
	0...1...2...3...4	Rapid or pounding heartbeat	
	0...1...2...3...4	Chest pain	_____
LUNGS	0...1...2...3...4	Chest congestion	
	0...1...2...3...4	Asthma, bronchitis	
	0...1...2...3...4	Shortness of breath	
	0...1...2...3...4	Difficulty breathing	_____

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DIGESTIVE TRACT	0...1...2...3...4	Nausea, vomiting	
	0...1...2...3...4	Diarrhea	
	0...1...2...3...4	Constipation	
	0...1...2...3...4	Bloated feeling	
	0...1...2...3...4	Belching, passing gas	
	0...1...2...3...4	Heartburn	
	0...1...2...3...4	Intestinal/stomach pain	_____
JOINTS & MUSCLE	0...1...2...3...4	Pain or aches in joints	
	0...1...2...3...4	Arthritis	
	0...1...2...3...4	Stiffness or limitation of movement	
	0...1...2...3...4	Pain or aches in muscles	
	0...1...2...3...4	Feeling of weakness or tiredness	_____
WEIGHT	0...1...2...3...4	Binge eating/drinking	
	0...1...2...3...4	Craving certain foods	
	0...1...2...3...4	Excessive weight	
	0...1...2...3...4	Compulsive eating	
	0...1...2...3...4	Water retention	
	0...1...2...3...4	Underweight	_____
	0...1...2...3...4	Fatigue, sluggishness	
ENERGY & ACTIVITY	0...1...2...3...4	Apathy, lethargy	
	0...1...2...3...4	Hyperactivity	
	0...1...2...3...4	Restlessness	_____
	0...1...2...3...4	Poor memory	
MIND	0...1...2...3...4	Confusion, poor comprehension	
	0...1...2...3...4	Poor concentration	
	0...1...2...3...4	Poor physical coordination	
	0...1...2...3...4	Difficulty in making decisions	
	0...1...2...3...4	Stuttering or stammering	
	0...1...2...3...4	Slurred speech	
	0...1...2...3...4	Learning disabilities	_____
	EMOTIONS	0...1...2...3...4	Mood swings
0...1...2...3...4		Anxiety, fear, nervousness	
0...1...2...3...4		Anger, irritability, aggressiveness	
0...1...2...3...4		Depression	_____
OTHER	0...1...2...3...4	Frequent illness	
	0...1...2...3...4	Frequent or urgent urination	
	0...1...2...3...4	Genital itch or discharge	_____
GRAND TOTAL			_____