

# Medical Symptoms Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Week \_\_\_\_\_

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