

# 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 \_\_\_\_\_

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