

# Medical Symptoms Questionnaire

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

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale: 0- **Never or almost never** have the symptom      3- **Frequently have it**, effect is not **severe**

1- **Occasionally have it**, effect is **not severe**

4- **Frequently have it**, effect is **severe**

2- **Occasionally 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

Total \_\_\_\_\_

*(Does not include near or far-sightedness)*

## EARS

\_\_\_\_\_ Itchy ears

\_\_\_\_\_ Earaches, ear infections

\_\_\_\_\_ Drainage from ear

\_\_\_\_\_ Ringing in ears, hearing loss

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 \_\_\_\_\_

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**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 joints
  - 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, nervousness
  - Depression
  - Feeling of weakness or tiredness
- Total\_\_\_\_\_
- 

**OTHER**

- Frequent illness
  - Frequent or urgent urination
  - Genital itching or discharge
- Total\_\_\_\_\_
- 

**TOTAL**

Overall Total: \_\_\_\_\_