

Medical Symptom Questionnaire

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	3	Frequently have it, effect is <i>not</i> severe
	1	Occasionally have it, effect is <i>not</i> 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
(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
or 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 _____