

# 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 \_\_\_\_\_

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