MEDICAL SYMPTOMS QUESTIONNAIRE

DATE___________ DR__________________ PATIENT_______________________________ #________

Rate each of the following symptoms based upon your typical health profile for:

☐ Past 30 days ☐ Past 48 hours Week________

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________

OVER ➔

DATE__________ DR_________________ PATIENT_____________________________ #_______

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	3 - *Frequently* have it, effect is *not severe*
	4 - *Frequently* have it, effect is *severe*

Category	Score	Symptom	Total
LUNGS	________	Chest congestion	
	________	Asthma, bronchitis	
	________	Shortness of breath	
	________	Difficulty breathing	Total_______
DIGESTIVE TRACT	________	Nausea, vomiting	
	________	Diarrhea	
	________	Constipation	
	________	Bloated 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_______

BOTH SIDE TOTAL ______

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