Medical Symptoms Questionnaire

Name: ______________________________ DOB: ______________ Date: ______________

Rate each of the following symptoms that apply to you, based upon your typical health profile for the past 30 days:

Point Scale:
0 - Never **or** Almost Never Have the Symptom
1 - Occasionally Have Symptom, Effect **Is Not** Severe
2 - Occasionally Have Symptom, Effect **Is** Severe
3 – Frequently Have Symptom, Effect **Is Not** Severe
4 - Frequently Have Symptom, Effect **Is** Severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia — Total _____

Eyes
_____ Watery or Itchy Eyes
_____ Swollen, Red or Sticky Eyelid
_____ 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
_____ Gagging, Frequent Throat Clearing
_____ 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
_____ Chronic Coughing
_____ Asthma / Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing — Total _____

Medical Symptoms Questionnaire (cont.)

Name: ______________________________ DOB: ____________ Date: ____________

Digestive Tract

_____ Nausea / Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching / Passing Gas
_____ Heartburn
_____ Intestinal / Stomach Pain — Total _____

Joints / Muscles

_____ 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 Making Decisions
_____ Stuttering / Stammering
_____ Slurred Speech
_____ Learning Disabilities — Total _____

Emotions

_____ Mood Swings
_____ Anxiety / Fear / Nervousness
_____ Anger / Irritability / Aggressiveness
_____ Depression — Total _____

Sexual

_____ Vaginal Dryness
_____ Decreased Sex Drive
_____ Poor Genital Sensation
_____ Lack of **or** Difficulty Having Orgasm
_____ Difficulty with Erection
_____ Difficulty with Ejaculation — Total _____

Other

_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge — Total _____

Grand Total _____