MEDICAL SYMPTOM QUESTIONNAIRE

PATIENT NAME: ___________________________________ DATE: ____________________________________

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

POINT SCALE:
- 0 = Never or almost never have the symptoms
- 1 = Occasionally, effect is NOT severe
- 2 = Occoasionally, effect is SEVERE
- 3 = Frequently, effect is NOT severe
- 4 = Frequently, effect is SEVERE

HEAD
- ______ Headaches
- ______ Faintness
- ______ Dizziness
- ______ Insomnia
- ______ **TOTAL**

MOUTH/THROAT
- ______ Chronic coughing
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, loss of voice
- ______ Swollen or discolored tongue, gums, lips
- ______ Canker sores
- ______ **TOTAL**

EYES
- ______ Watery, itchy eyes
- ______ Swollen, red, sticky eyelids
- ______ Bags/dark circles under eyes
- ______ Blurred or tunnel vision (not near or farsighted)
- ______ **TOTAL**

SKIN
- ______ Acne
- ______ Hives, rash
- ______ Dry skin
- ______ Hair Loss
- ______ Flushing
- ______ Excessive sweating
- ______ **TOTAL**

EARS
- ______ Itchy ears
- ______ Earaches, ear infections
- ______ Ear drainage
- ______ Ringing in ears, hearing loss
- ______ **TOTAL**

NOSE
- ______ Stuffy nose
- ______ Sinus problems
- ______ Hay fever
- ______ Sneezing attackes
- ______ Excess mucus formed
- ______ **TOTAL**

HEART
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat
- ______ Chest pain
- ______ **TOTAL**

LUNGS
- ______ Chest congestion
- ______ Asthma, bronchitis
- ______ Shortness of breath
- ______ Difficulty breathing
- ______ **TOTAL**

EMOTIONS
- ______ Mood swings
- ______ Anxiety, fear, nerveousness
- ______ Anger, irritable, aggressive
- ______ Depression
- ______ **TOTAL**

DIGESTIVE TRACT
- ______ Nausea, vomiting
- ______ Diarrhea
- ______ Consitpation
- ______ Bloated
- ______ Belching, gas
- ______ Heartburn
- ______ Stomach pain
- ______ **TOTAL**

JOINTS / MUSCLES
- ______ Pain / aches in joints
- ______ Arthritis
- ______ Stiffness, limited in movement
- ______ Pain / aches in muscles
- ______ Feeling of weakness, tiredness
- ______ **TOTAL**

MIND
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Difficulty make decisions
- ______ Stuttering / stammering
- ______ Slurred speech
- ______ Learning disabilities
- ______ **TOTAL**

ENERGY / ACTIVITY
- ______ Fatigue
- ______ Apathy, lethargy
- ______ Hyperactivity
- ______ Restlessness
- ______ **TOTAL**

WEIGHT
- ______ Binge eating / drinking
- ______ Craving certain foods
- ______ Excessive weight
- ______ Compulsive eating
- ______ Water retention
- ______ Underweight
- ______ **TOTAL**

OTHER
- ______ Frequent illness
- ______ Frequent / urgent urination
- ______ Genital itch / discharge
- ______ **TOTAL**

GRAND TOTAL ______