



MEDICAL SYMPTOMS QUESTIONNAIRE

Name _____

Date _____

Rate each of the following symptoms based upon your typical health profile for: Past 48 Hrs

- 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

0		Headaches	
0		Faintness	
0		Dizziness	
0		Insomnia	
			Total 0

EYES

0		Watery or itchy eyes	
0		Swollen, reddened or sticky eyelids	
0		Bags or dark circles under eyes	
0		Blurred or tunnel vision (does not include near or far-sightedness)	
			Total 0

EARS

0		Itchy ears	
0		Earaches, ear infections	
0		Drainage from ear	
0		Ringling in ears, hearing loss	
			Total 0

NOSE

0		Stuffy nose	
0		Sinus problems	
0		Hay fever	
0		Sneezing attacks	
0		Excessive mucus formation	
			Total 0

MOUTH/THROAT

0		Chronic coughing	
0		Gagging, frequent need to clear throat	
0		Sore throat, hoarseness, loss of voice	
0		Swollen or discolored tongue, gums, lips	
0		Canker sores	
			Total 0

SKIN

0		Acne	
0		Hives, rashes, dry skin	
0		Hair loss	
0		Flushing, hot flashes	
0		Excessive sweating	
			Total 0

HEART

0		Irregular or skipped heartbeat	
0		Rapid or pounding heartbeat	
0		Chest pain	
			Total 0

LUNGS	<u> 0 </u>	Chest congestion	
	<u> 0 </u>	Asthma, bronchitis	
	<u> 0 </u>	Shortness of breath	
	<u> 0 </u>	Difficulty breathing	Total <u> 0 </u>
DIGESTIVE TRACT	<u> 0 </u>	Nausea, vomiting	
	<u> 0 </u>	Diarrhea	
	<u> 0 </u>	Constipation	
	<u> 0 </u>	Bloated feeling	
	<u> 0 </u>	Belching, passing gas	
	<u> 0 </u>	Heartburn	
	<u> 0 </u>	Intestinal/stomach pain	Total <u> 0 </u>
JOINTS/MUSCLE	<u> 0 </u>	Pain or aches in joints	
	<u> 0 </u>	Arthritis	
	<u> 0 </u>	Stiffness or limitation of movement	
	<u> 0 </u>	Pain or aches in muscles	
	<u> 0 </u>	Feeling of weakness or tiredness	Total <u> 0 </u>
WEIGHT	<u> 0 </u>	Binge eating/drinking	
	<u> 0 </u>	Craving certain foods	
	<u> 0 </u>	Excessive weight	
	<u> 0 </u>	Compulsive eating	
	<u> 0 </u>	Water retention	
	<u> 0 </u>	Underweight	Total <u> 0 </u>
ENERGY/ACTIVITY	<u> 0 </u>	Fatigue, sluggishness	
	<u> 0 </u>	Apathy, lethargy	
	<u> 0 </u>	Hyperactivity	
	<u> 0 </u>	Restlessness	Total <u> 0 </u>
MIND	<u> 0 </u>	Poor memory	
	<u> 0 </u>	Confusion, poor comprehension	
	<u> 0 </u>	Poor concentration	
	<u> 0 </u>	Poor physical coordination	
	<u> 0 </u>	Difficulty in making decisions	
	<u> 0 </u>	Stuttering or stammering	
	<u> 0 </u>	Slurred speech	
	<u> 0 </u>	Learning disabilities	Total <u> 0 </u>
EMOTIONS	<u> 0 </u>	Mood swings	
	<u> 0 </u>	Anxiety, fear, nervousness	
	<u> 0 </u>	Anger, irritability, aggressiveness	
	<u> 0 </u>	Depression	Total <u> 0 </u>
OTHER	<u> 0 </u>	Frequent illness	
	<u> 0 </u>	Frequent or urgent urination	
	<u> 0 </u>	Genital itch or discharge	Total <u> 0 </u>
GRAND TOTAL		TOTAL	<u> 0 </u>