**FRONT AND BACK**

TOTAL NUTRITION
AND THERAPEUTICS

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

GRAND TOTAL *TOTAL* 0