

# Medical Symptoms Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the past 30 days:

- 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-sighted)
- \_\_\_\_\_ **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, or 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
- \_\_\_\_\_ Asthma, Bronchitis
- \_\_\_\_\_ Shortness of Breath
- \_\_\_\_\_ Difficulty Breathing
- \_\_\_\_\_ **Total**

**DIGESTIVE TRACT**

- \_\_\_\_\_ Nausea, Vomiting
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Bloating 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 Condition
- \_\_\_\_\_ 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**

**GRAND TOTAL** \_\_\_\_\_