

# Medical Symptoms Questionnaire

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

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

Past 30 days       Past 48 hours

## 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-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**

\_\_\_\_\_ Chronic coughing  
\_\_\_\_\_ Gagging, frequent need to clear throat  
\_\_\_\_\_ 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  
 \_\_\_\_\_ 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 coordination  
 \_\_\_\_\_ 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** \_\_\_\_\_ **TOTAL** \_\_\_\_\_