Name: ____________________

Last 4 SSN: ____________________

Medical Symptom Questionnaire

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

Never/almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
0	1	2	3	4

HEAD

______	Headaches
+ ______	Faintness
+ ______	Dizziness
+ ______	Insomnia
=	**Total**

EYES

______	Watery or Itch
+ ______	Swollen, reddened or sticky eyelids
+ ______	Bags or dark circles under eyes
+ ______	Blurred or Tunnel vision (Does not include near or far-sightedness)
=	**Total**

NOSE

______	Stuffy nose
+ ______	Sinus problems
+ ______	Hay Fever
+ ______	Sneezing attacks
+ ______	Excessive mucus formation
=	**Total**

EARS

______	Itchy ears
+ ______	Earaches, Infections
+ ______	Drainage from ear
+ ______	Ringing in ears, hearing loss
=	**Total**

MOUTH/THROAT

______	Chronic coughing
+ ______	Gagging, frequent need to clear throat
+ ______	Sore, hoarseness, loss of voice
+ ______	Swollen/discolored tongue, gums, lips
+ ______	Canker sores
=	**Total**

SKIN

______	Acne
+ ______	Hives, rashes, dry skin
+ ______	Hair loss
+ ______	Flushing, hot flashes
+ ______	Excessive sweating
=	**Total**

= **TOTAL** Page 1

Never/almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
0	1	2	3	4

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
+ ______ Bloated 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**

ENERGY/ACTIVITY

______ Fatigue, sluggishness
+ ______ Apathy, lethargy
+ ______ Hyperactivity
+ ______ Restlessness

= ______ **Total**

WEIGHT

______ Binge eating/drinking
+ ______ Craving certain foods
+ ______ Excessive weight
+ ______ Compulsive eating
+ ______ Water retention

= ______ **Total**

MIND

______ Poor Memory
+ ______ Confusion, poor comprehension
+ ______ 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**

= **TOTAL** Page 2

+ **TOTAL** Page 1

= **GRAND TOTAL**