The Center for Medicine and Healing Arts

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Heart. Hope. Healing

Medical Symptoms Questionnaire

Name________________________________ Date ________________________________

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 — Total _________
(does not include near or far-sightedness)

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