Medical Symptoms

/ Questionnaire

Patient Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 — ***Never or almost never*** have the symptom

1 — ***Occassionally*** have it, effect ***is not severe***

2 — ***Occassionally*** 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 _____

/ Ears

_____ Itchy Ears

_____ Earaches, Ear Infection

_____ Drainage from Ear(s)

_____ Ringing in Ears, Hearing Loss

Total _____

/ Eyes

_____ Watery/Itchy Eyes

_____ Swollen, Reddened, Sticky Eyelids

_____ Bags, Dark Circles Under Eyes

_____ Blurred/Tunnel Vision*

*Does not include near or far-sightedness

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/Discolored Tongue, Gums, Lips

_____ Canker Sores

Total _____

/ Skin

_____ Acne

_____ Hives, Rashes, Dry Skin

_____ Hair Loss

_____ Flushing, Hot Flashes

_____ Excessive Sweating

Total _____

/ Heart

_____ Irregular/Skipped Heartbeat

_____ Rapid, Pounding Heartbeat

_____ Chest Pain

Total _____

/ Lungs

_____ Chest Congestion

_____ Asthma, Bronchitis

_____ Shortness of Breath

_____ Difficultly Breathing

Total _____

/ Digestive Tract

_____ Nausea, Vomiting

_____ Diarrhea

_____ Constipation

_____ Bloated

_____ Belching, Passing Gas

_____ Heartburn

_____ Intestinal, Stomach Pain

Total _____

/ Joints + Muscle

_____ Pain, Aches in Joints

_____ Arthritis

_____ Stiffness, Limitation of Movement

_____ Pain or Aches in Muscles

_____ Feeling of Weakness, 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, Stammering

_____ Slurred Speech

_____ Learning Disabilities

Total _____

/ Emotions

_____ Mood Swings

_____ Anxiety, Fear, Nervousness

_____ Anger, Irritability, Aggressiveness

_____ Depression

Total _____

/ Other

_____ Frequent Illness

_____ Frequent/Urgent Urination

_____ Genital Itch/Discharge

Total _____