

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name _____ Date _____

Using the point scale, 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-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 _____

