

**Medical Symptoms Questionnaire (MSQ)**

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. – ***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***

Headaches

**HEAD**

 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**  |

Version 2

 **MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)**

 Chest congestion

**LUNGS**

 Asthma, bronchitis

 Shortness of breath

 Difficulty breathing **Total**

Nausea, vomiting

**DIGESTIVE TRACT**

 Diarrhea

 Constipation

 Bloated feeling

 Belching, passing gas

 Heartburn

 Intestinal/stomach pain **Total**

Pain or aches in joints

**JOINTS/MUSCLE**

 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**  |

Mood swings

**EMOTIONS**

 Anxiety, fear, nervousness

 Anger, irritability, aggressiveness

 Depression **Total**

Frequent illness

**OTHER**

 Frequent or urgent urination

 Genital itch or discharge **Total Grand Total**