MSQ

Medical Symptoms Questionnaire

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 = Frequently have it, effect is not severe
3 = Occasionally have it, effect is severe
4 = Frequently have it, effect is severe

Digestive Tract	____ Nausea or vomiting ____ Diarrhea ____ Constipation ____ Bloated Feeling ____ Belching or passing gas ____ Heartburn	Total ____	**Lungs**	____ Chest congestion ____ Asthma, bronchitis ____ Shortness of breath ____ Difficulty breathing	Total ____
Ears	____ Itchy ears ____ Ear aches, ear infections ____ Drainage from ears ____ Ringing in ears, hearing loss	Total ____	**Mind**	____ Poor memory ____ Confusion, poor comprehension ____ Difficulty in making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities	Total ____
Emotions	____ Mood swings ____ Anxiety, fear, or nervousness ____ Anger, irritability, or aggressiveness ____ Depression	Total ____	**Mouth/ Throat**	____ Chronic coughing ____ Gagging frequently; need to clear throat ____ Sore throat, hoarseness, loss of voice ____ Swollen/discolored tongue/gums/lips ____ Canker sores	Total ____
Energy & Activity	____ Fatigue, sluggishness ____ Apathy, lethargy ____ Hyperactivity ____ Restlessness	Total ____	**Nose**	____ Stuffy nose ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ Excessive mucus formation	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 ____	**Skin**	____ Acne ____ Hives, rashes, or dry skin ____ Hair loss ____ Flushing or hot flashes ____ Excessive sweating	Total ____
Head	____ Headaches ____ Faintness ____ Dizziness ____ Insomnia	Total ____	**Weight**	____ Binge eating ____ Craving certain foods ____ Excessive weight ____ Compulsive eating ____ Water retention ____ Underweight	Total ____
Heart	____ Irregular or skipped heartbeat ____ Rapid or pounding heartbeat ____ Chest pain	Total ____	**Other**	____ Frequent illness ____ Frequent or urgent urination ____ Genital itch or discharge	Total ____
Joint & Muscles	____ Pain or aches in joints ____ Arthritis ____ Stiffness or limitation of movement ____ Pain or aches in muscles ____ Feeling of weakness or tiredness	Total ____		***Grand Total***	_____