JLOPEZMD

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***

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 ________

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_________ Chest congestion
_________ Asthma, bronchitis
_________ Shortness of breath
_________ Difficulty breathing

Total _________

DIGESTIVE TRACT

_________ Nausea, vomiting
_________ Diarrhea
_________ Constipation
_________ Bloated feeling
_________ Belching, passing gas
_________ Heartburn
_________ Intestinal/stomach pain

Total _________

JOINTS/MUSCLE

_________ Pain or aches in joints
_________ 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 _________

EMOTIONS

_________ Mood swings
_________ Anxiety, fear, nervousness
_________ Anger, irritability, aggressiveness
_________ Depression

Total _________

OTHER

_________ Frequent illness
_________ Frequent or urgent urination
_________ Genital itch or discharge

Total _________

Grand Total _________