MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness and helps track your progress over time.

Rate each of the following symptoms based upon your health profile for the past 30 days.

If you are taking this after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting ___ Diarrhea ___ Constipation ___ Belching or gas ___ Heartburn ___

Bloated feeling ___ Intestinal/Stomach pain TOTAL: _____

EARS

___ Itchy ears Total ___ Earaches, ear infections ___ Drainage from ear ___ Ringing in ears, hearing loss

TOTAL: _____

ENERGY

___ Fatigue / low energy ___ Lethargy / apathy ___ Restlessness ____ Hyperactivity ___ TOTAL: _____

EMOTIONS

___ Mood swings ___ Anxiety / fear or nervousness ___Depression ___ Anger, irritability, aggressiveness
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 farsightedness) TOTAL: _____

HEAD

___ Headaches ___ Faintness ___ Dizziness ___ Insomnia TOTAL: _____

HEART

___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat ___ Chest 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: _____

LUNGS

___ Chest congestion ___ Asthma, bronchitis ___ Shortness of breath ___ Difficult breathing

TOTAL: _____

MIND

___ Poor memory ___ Confusion, poor comprehension ___ Poor concentration ___ Slurred speech ___ Poor physical coordination ___ Difficulty in making decisions ___ Stuttering or stammering TOTAL: _____

MOUTH/THROAT

___ Chronic coughing ___ Gagging frequent need to clear throat ___ Sore throat, hoarseness, loss of voice ___ Swollen/discolored tongue, gum, lips ___ Canker sores ___ Difficulty swallowing

TOTAL: _____

NOSE

___ Stuffy nose ___ Sinus problems ___ Hay fever ___ Sneezing attacks ___ Excessive mucus formation

TOTAL: _____

SKIN

___ Acne ___ Hives, rashes, or dry skin ___ Hair loss ___ Flushing or hot flushes ___ Excessive sweating

___ Increased facial or body hair TOTAL: _____

WEIGHT

___ Binge eating/drinking ___ Craving certain foods ___ Excessive weight ___ Compulsive eating ___ Water retention ___ Underweight TOTAL: _____

FEMALE HEALTH

___ PMS ___ Cramps during period ___ No periods ___ Frequent Periods ___ Irregular Periods ___ Heavy Periods TOTAL: _____

OTHER

___ Frequent illness ___ Frequent or urgent urination ___ Genital itch or discharge ___ Low interest in sex / low libido TOTAL: _____

Grand Total _____