



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	<input type="text"/> Headaches <input type="text"/> Faintness <input type="text"/> Dizziness <input type="text"/> Insomnia	Total _____
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EYES	<input type="text"/> Watery or itchy eyes <input type="text"/> Swollen, reddened or sticky eyelids <input type="text"/> Bags or dark circles under eyes <input type="text"/> Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	Total _____
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EARS	<input type="text"/> Itchy ears <input type="text"/> Earaches, ear infections <input type="text"/> Drainage from ear <input type="text"/> Ringing in ears, hearing loss	Total _____
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NOSE	<input type="text"/> Stuffy nose <input type="text"/> Sinus problems <input type="text"/> Hay fever <input type="text"/> Sneezing attacks <input type="text"/> Excessive mucus formation	Total _____
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MOUTH/THROAT	<input type="text"/> Chronic coughing <input type="text"/> Gagging, frequent need to clear throat <input type="text"/> Sore throat, hoarseness, loss of voice <input type="text"/> Swollen or discolored tongue, gums, lips <input type="text"/> Canker sores	Total _____
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SKIN	<input type="text"/> Acne <input type="text"/> Hives, rashes, dry skin <input type="text"/> Hair loss <input type="text"/> Flushing, hot flashes <input type="text"/> Excessive sweating	Total _____
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HEART	<input type="text"/> Irregular or skipped heartbeat <input type="text"/> Rapid or pounding heartbeat <input type="text"/> Chest pain	Total _____
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MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

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

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloating feeling
_____ Belching or 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 _____