

Medical Symptoms Questionnaire (MSQ)

Patient Nam	e	Date	
Date cash -	f the fellowing symptoms based were trees	sign boulds profile for the court 14 days	
	 of the following symptoms based upon your typ 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	
HEAD			
HEAD	Headaches Faintness Dizziness Insomnia	Total	
EYES	Watery or itchy eyes Swollen, reddened of Bags or dark circles Blurred or tunnel vi	or sticky eyelids under eyes	
	(Does not include nea	r or far-sightedness)	
EARS	Itchy ears Earaches, ear infection Drainage from ear Ringing in ears, hea		
NOSE	Stuffy nose Sinus problems Hay fever Sneezing attacks Excessive mucus for	rmation Total	
MOUTH/T	Gagging, frequent n Sore throat, hoarsen		
SKIN	Acne Hives, rashes, dry sk Hair loss Flushing, hot flashes Excessive sweating		
HEART	Irregular or skipped Rapid or pounding Chest pain		

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

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