

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 3 – *Frequently* have it, effect is *not severe*
 1 – *Occasionally* have it, effect is *not severe* 4 – *Frequently* have it, effect is *severe*
 2 – *Occasionally* have it, effect is *severe*

HEAD

_____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia

Total 0 _____

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 0 _____

EARS

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

Total 0 _____

NOSE

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

Total 0 _____

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 0 _____

SKIN

_____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Flushing, hot flashes
 _____ Excessive sweating

Total 0 _____

HEART

_____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain

Total 0 _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

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

Total 0 _____

DIGESTIVE TRACT

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloating feeling
- _____ Belching, passing gas
- _____ Heartburn
- _____ Intestinal/stomach pain

Total 0 _____

JOINTS/MUSCLE

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness or limitation of movement
- _____ Pain or aches in muscles
- _____ Feeling of weakness or tiredness

Total 0 _____

WEIGHT

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Compulsive eating
- _____ Water retention
- _____ Underweight

Total 0 _____

ENERGY/ACTIVITY

- _____ Fatigue, sluggishness
- _____ Apathy, lethargy
- _____ Hyperactivity
- _____ Restlessness

Total 0 _____

MIND

- _____ Poor memory
- _____ Confusion, poor comprehension
- _____ Poor concentration
- _____ Poor physical coordination
- _____ Difficulty in making decisions
- _____ Stuttering or stammering
- _____ Slurred speech
- _____ Learning disabilities

Total 0 _____

EMOTIONS

- _____ Mood swings
- _____ Anxiety, fear, nervousness
- _____ Anger, irritability, aggressiveness
- _____ Depression

Total 0 _____

OTHER

- _____ Frequent illness
- _____ Frequent or urgent urination
- _____ Genital itch or discharge

Total 0 _____

Grand Total 0 _____