Medical Symptoms Questionnaire (MSQ)

Name: **Date:**

Rate each of the following symptoms based upon your typical health profile for:

☒ *Past 30 days* ☐ *Past 48 hours*

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/sticky eyelids
____ Bags, dark circles
____ Blurred or tunnel vision *(does not include near or far-sightedness)*
TOTAL _____

EARS
____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing /hearing loss
TOTAL _____

NOSE
____ Stuffy Nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucous
TOTAL _____

MOUTH/THROAT
____ Chronic coughing
____ Gagging/throat clearing
____ Sore throat, hoarseness, loss of voice
____ Swollen/discolored tongue, gums, lips
____ Canker sores
TOTAL _____

HEART
____ Irregular /skipped beats
____ Rapid/pounding beats
____ Chest pain
TOTAL _____

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

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/limited 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
____ Jetlag
TOTAL _____

MIND
____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty 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
____ Bone pain
TOTAL ____

GRAND TOTAL _____