Name: _____

Date:_____

# MSQ - Medical Symptoms Questionnaire

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

**Point Scale:**

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Frequently have it, effect is not severe
3 = Occasionally have it, effect is severe
4 = Frequently have it, effect is severe

| | | |
|---|---|---|
| Digestive Tract | _____Nausea or vomiting<br>_____Diarrhea<br>_____Constipation<br>_____Bloated Feeling<br>_____Belching or passing gas<br>_____Heartburn | Total<br>_____ |
| Ears | _____Itchy Ears<br>_____Ear aches, ear infections<br>_____Drainage from ear<br>_____Ringing in ears, hearing loss | Total<br>_____ |
| Emotions | _____Mood Swings<br>_____Anxiety, fear or nervousness<br>_____Anger, irritability or aggressiveness<br>_____Depression | Total<br>_____ |
| Energy & Activity | _____Fatigue, sluggishness<br>_____Apathy, lethargy<br>_____Hyperactivity<br>_____Restlessness | Total<br>_____ |
| Eyes | _____Watery or itchy eyes<br>_____Swollen, reddened or sticky eyelids<br>_____Bags or dark circles under eyes<br>_____Blurred or tunnel vision<br>[does not include near or far sightedness] | Total<br>_____ |
| Head | _____Headaches<br>_____Faintness<br>_____Dizziness<br>_____Insomnia | Total<br>_____ |
| Heart | _____Irregular or skipped heartbeat<br>_____Rapid or pounding heartbeat<br>_____Chest Pain | Total<br>_____ |
| Joints & Muscles | _____Pain or aches in joints<br>_____Arthritis<br>_____Stiffness or limitation of movement<br>_____Pain or aches in muscles<br>_____Feeling of weakness or tiredness | Total<br>_____ |

| | | |
|---|---|---|
| Lungs | _____Chest Congestion<br>_____Asthma, bronchitis<br>_____Shortness of breath<br>_____Difficulty Breathing | Total<br>_____ |
| Mind | _____Poor memory<br>_____Confusion, poor comprehension<br>_____Difficulty in making decisions<br>_____Stuttering or stammering<br>_____Slurred speech<br>_____Learning disabilities | Total<br>_____ |
| Mouth/Throat | _____Chronic coughing<br>_____Gagging frequently; need to clear throat<br>_____Sore throat, hoarseness, loss of voice<br>_____Swollen or discolored tongue, gums, lips<br>_____Canker Sores | Total<br>_____ |
| Nose | _____Stuffy nose<br>_____Sinus problems<br>_____Hay fever<br>_____Sneezing attacks<br>_____Excessive mucus formation | Total<br>_____ |
| Skin | _____Acne<br>_____Hives, rashes, or dry skin<br>_____Hair loss<br>_____Flushing or hot flashes<br>_____Excessive sweating | Total<br>_____ |
| Weight | _____Binge eating/drinking<br>_____Craving certain foods<br>_____Excessive weight<br>_____Compulsive eating<br>_____Water retention<br>_____Underweight | Total<br>_____ |
| Other | _____Frequent illness<br>_____Frequent or urgent urination<br>_____Genital itch or discharge | Total<br>_____ |
| **Grand Total** | | _____ |