



Medical Symptoms Questionnaire

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 or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision
(does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

Total _____

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 _____

SKIN

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

Total _____

Medical Symptoms Questionnaire

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		TOTAL	_____

This form was created by The Institute for Functional Medicine. www.functionalmedicine.org.