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		Total
	________Nausea or vomiting	
	________Diarrhea	
	________Constipation	
	________Bloated Feeling	
	________Belching or passing gas	
	________Heartburn	_______

Ears		Total
	________Itchy Ears	
	________Ear aches, ear infections	
	________Drainage from ear	
	________Ringing in ears, hearing loss	_______

Emotions		Total
	________Mood Swings	
	________Anxiety, fear or nervousness	
	________Anger, irritability or aggressiveness	
	________Depression	_______

Energy & Activity		Total
	________Fatigue, sluggishness	
	________Apathy, lethargy	
	________Hyperactivity	
	________Restlessness	_______

Eyes		Total
	________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]	_______

Head		Total
	________Headaches	
	________Faintness	
	________Dizziness	
	________Insomnia	_______

Heart		Total
	________Irregular or skipped heartbeat	
	________Rapid or pounding heartbeat	
	________Chest Pain	_______

Joints & Muscles		Total
	________Pain or aches in joints	
	________Arthritis	
	________Stiffness or limitation of movement	
	________Pain or aches in muscles	
	________Feeling of weakness or tiredness	_______

Lungs		Total
	________Chest Congestion	
	________Asthma, bronchitis	
	________Shortness of breath	
	________Difficulty Breathing	_______

Mind		Total
	________Poor memory	
	________Confusion, poor comprehension	
	________Difficulty in making decisions	
	________Stuttering or stammering	
	________Slurred speech	
	________Learning disabilities	_______

Mouth/Throat		Total
	________Chronic coughing	
	________Gagging frequently; need to clear throat	
	________Sore throat, hoarseness, loss of voice	
	________Swollen or discolored tongue, gums, lips	
	________Canker Sores	_______

Nose		Total
	________Stuffy nose	
	________Sinus problems	
	________Hay fever	
	________Sneezing attacks	
	________Excessive mucus formation	_______

Skin		Total
	________Acne	
	________Hives, rashes, or dry skin	
	________Hair loss	
	________Flushing or hot flashes	
	________Excessive sweating	_______

Weight		Total
	________Binge eating/drinking	
	________Craving certain foods	
	________Excessive weight	
	________Compulsive eating	
	________Water retention	
	________Underweight	_______

Other		Total
	________Frequent illness	
	________Frequent or urgent urination	
	________Genital itch or discharge	_______

Grand Total _______