MEDICAL SYMPTOMS QUESTIONNAIRE

CHICAGO INSTITUTE FOR HEALTH AND WELLNESS
ANSWERS - OPTIONS - RESULTS

Patient Name:_____ **Date:**_____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past Month ❒ Past Week ❒ Past 48 Hours

Point Scale: **0 Never or almost never have the symptom** **1 Occassionally have it, effect is not servere** **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 eyes or sticky Eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **Total** _____

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

Mouth Throat
_____ Chronic coughing
_____ Gagging, Frequent need to Clear throat
_____ Sore throat, hoarsement 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
_____ Chest pain
_____ Irregular or skipped heart beat
_____ Rapid or pounding Heartbeat **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** _____

Joint/ Muscle
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness of tiredness
_____ Pain or aches in muscle **Total** _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating **Total** _____

Energy/ Activity
_____ Fatique,sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlesness **Total** _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
Total _____

Emotions
_____ Mood swings
_____ Anxiety fear, nervousness
_____ Anger, irritablitiy, aggressiveness
_____ Depression **Total** _____

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genitial itch or discharge **Total** _____

Grand Total **Total** _____

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