Medical Symptoms Questionnaire (MSQ)

Patient Name _______________________________________________________________ Date ___________________

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

**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 (MSQ)

#### 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**