



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 3 – *Frequently* have it, effect is *not severe*
1 – *Occasionally* have it, effect is *not severe* 4 – *Frequently* have it, effect is *severe*
2 – *Occasionally* 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
- Total** _____
- (Does not include near or far-sightedness)*

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
 - _____ Bloating 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 _____