Medical Symptoms Questionnaire (MSQ)

Name: ____ Date: ________________

Email Address: ____

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 - 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-sighted)
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, or 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 _______

Lungs	______	Chest Congestion
	______	Asthma, Bronchitis
	______	Shortness of Breath
	______	Difficulty Breathing
		Total ______
Digestion	______	Nausea, Vomiting
	______	Diarrhea
	______	Constipation
	______	Bloated Feeling
	______	Belching, Passing Gas
	______	Heartburn
	______	Intestinal/Stomach Pain
		Total ______
Joints/ Muscles	______	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 Condition
	______	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 ______