## 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** _______