

MSQ - Medical Symptoms Questionnaire

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 = Frequently have it, effect is not severe

3 = Occasionally have it, effect is severe

4 = Frequently have it, effect is severe

Digestive Tract	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching or passing gas <input type="checkbox"/> Heartburn	Total	Lungs	<input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty Breathing	Total
	<input type="checkbox"/> Itchy Ears <input type="checkbox"/> Ear aches, ear infections <input type="checkbox"/> Drainage from ears <input type="checkbox"/> Ringing in ears, hearing loss	Total		Mind	<input type="checkbox"/> Poor memory <input type="checkbox"/> Confusion, poor comprehension <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Stuttering or stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities
Emotions	<input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear or nervousness <input type="checkbox"/> Anger, irritability or aggressiveness <input type="checkbox"/> Depression	Total	Mouth/ Throat		<input type="checkbox"/> Chronic coughing <input type="checkbox"/> Gagging frequently; need to clear throat <input type="checkbox"/> Sore throat, hoarseness, loss of voice <input type="checkbox"/> Swollen or discolored tongue, gums, lips <input type="checkbox"/> Canker sores
	<input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Total		Nose	<input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hay fever <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Excessive mucus formation
Energy & Activity	<input type="checkbox"/> Watery or itchy eyes <input type="checkbox"/> Swollen, reddened or sticky eyelids <input type="checkbox"/> Bags or dark circles under eyes <input type="checkbox"/> Blurred or tunnel vision (does not include near or far sightedness)	Total	Skin		<input type="checkbox"/> Acne <input type="checkbox"/> Hives, rashes, or dry skin <input type="checkbox"/> Hair loss <input type="checkbox"/> Flushing or hot flashes <input type="checkbox"/> Excessive sweating
	<input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Total		Weight	<input type="checkbox"/> Binge eating <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight
Eyes	<input type="checkbox"/> Irregular or skipped heartbeat <input type="checkbox"/> Rapid or pounding heartbeat <input type="checkbox"/> Chest Pain	Total	Other		<input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> Genital itch or discharge
	<input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or limitation of movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness	Total		<i>Grand Total</i> _____	