



# 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  
*(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  
\_\_\_\_\_ 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** \_\_\_\_\_