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 __________

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