



# 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*

<b>HEAD</b>	<input type="text"/> Headaches <input type="text"/> Faintness <input type="text"/> Dizziness <input type="text"/> Insomnia	<b>Total</b> _____
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<b>EYES</b>	<input type="text"/> Watery or itchy eyes <input type="text"/> Swollen, reddened or sticky eyelids <input type="text"/> Bags or dark circles under eyes <input type="text"/> Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	<b>Total</b> _____
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<b>EARS</b>	<input type="text"/> Itchy ears <input type="text"/> Earaches, ear infections <input type="text"/> Drainage from ear <input type="text"/> Ringing in ears, hearing loss	<b>Total</b> _____
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<b>NOSE</b>	<input type="text"/> Stuffy nose <input type="text"/> Sinus problems <input type="text"/> Hay fever <input type="text"/> Sneezing attacks <input type="text"/> Excessive mucus formation	<b>Total</b> _____
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<b>MOUTH/THROAT</b>	<input type="text"/> Chronic coughing <input type="text"/> Gagging, frequent need to clear throat <input type="text"/> Sore throat, hoarseness, loss of voice <input type="text"/> Swollen or discolored tongue, gums, lips <input type="text"/> Canker sores	<b>Total</b> _____
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<b>SKIN</b>	<input type="text"/> Acne <input type="text"/> Hives, rashes, dry skin <input type="text"/> Hair loss <input type="text"/> Flushing, hot flashes <input type="text"/> Excessive sweating	<b>Total</b> _____
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<b>HEART</b>	<input type="text"/> Irregular or skipped heartbeat <input type="text"/> Rapid or pounding heartbeat <input type="text"/> Chest pain	<b>Total</b> _____
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## 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** \_\_\_\_\_