Medical Symptoms Questionnaire !

Name: _____ DOB: _____ Date: _____ !

This Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify underlying causes of illness and helps us track your progress. Rate each of the following symptoms based upon your typical health profile for the past 30 days. ***Please total your scores <u>within each section</u> and at the <u>bottom of the</u> page.***

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 or 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: _____ (

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/ Muscles _____ 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: _____

Optimal < 10, Mild Toxicity 10-50, Moderate Toxicity 50-100, Severe Toxicity >100

Total Score: _____

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Name: _____ Date:_____

Review of Current/ Recent Symptoms:

Please place an (X) in the appropriate boxes for CURRENT or ONGOING problems (within the past 1-3 months):

General	**Yes**	**No**	**Respiratory**	**Yes**	**No**	**Skin**	**Yes**	**No**
Fatigue			Chest pain			Acne		
Fever			**Cardiovascular**	**Yes**	**No**	Changes in moles		
Night sweats			Dizziness			Rash		
Sleep disturbance			Shortness of breath			Skin lesion(s)		
Weight gain			**Gastrointestinal**	**Yes**	**No**	**Neurologic**	**Yes**	**No**
Weight loss			Abdominal pain			Balance difficulty		
Ophthalmologic	**Yes**	**No**	Change in bowel habits			Dizziness		
Discharge			Constipation			Headache		
Dry eye			Diarrhea			Memory loss		
Itching and redness			Heartburn			Tingling/Numbness		
Pain			Nausea			Transient loss of vision		
ENT	**Yes**	**No**	**Women Only**	**Yes**	**No**	Tremor		
Hoarseness			Decreased Libido			**Psychiatric**	**Yes**	**No**
Nasal Congestion			Heavy bleeding			Mood swings		
Snoring			Hot flashes			Problems with focus		
Decreased hearing			Irregular menses			Anxiety		
Difficulty swallowing			Missed periods			Depressed mood		
Nosebleed			**Genitourinary**	**Yes**	**No**	Difficulty sleeping		
Sore throat			Blood in urine			Eating disorder		
Swollen glands			Change in bladder habits			Mental or Physical abuse		
Endocrine	**Yes**	**No**	STD concerns			Substance abuse		
Cold intolerance			**Musculoskeletal**	**Yes**	**No**			
Excessive sweating			Joint stiffness					
Excessive thirst			Muscle aches					
Heat intolerance			Weakness					