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 page</u>.***

<u>Point Scale</u>:

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: _____

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					

To help us make the most of your visit today, please identify the top 3 concerns/issues that we need to address today:

1. _____

2. _____

3. _____

Please let us know TODAY, if you have any medications needing refills. We can no longer accept phone calls for refills. If you do not make the request today, you will need to make an office visit to address that request.