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>.***

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: _______________

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.