



Helping women heal themselves

3 MARINA ROAD YARMOUTH, ME 04096  
PH: (207) 846-6163 FX: (207) 846-6167

MEDICAL SYMPTOMS QUESTIONNAIRE

Name: \_\_\_\_\_  
3 MARINA ROAD,  
YARMOUTH, ME 04096  
PH: (207) 846-6163  
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Date: \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:

Past 48 hours       Past 30 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 eyes  
 \_\_\_\_\_ 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: \_\_\_\_\_

LUNGS \_\_\_\_\_ Chest congestion  
 \_\_\_\_\_ Asthma, bronchitis  
 \_\_\_\_\_ Shortness of breath  
 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: \_\_\_\_\_**