women to women
Healthcare Center

Helping
women heal
themselves

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MEDICAL SYMPTOMS QUESTIONNAIRE

Name: _____ **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 <u>not</u> severe
2- Occasionally have it, effect is severe
3- Frequently have it, effect is <u>not</u> severe
4- Frequently have it, effect is severe

HEAD	_____	Headaches
	_____	Faintness
	_____	Dizziness
	_____	Insomnia
		Total: _____
EYES	_____	Watery, or Itchy eyes
	_____	Blurred, or tunnel vision (does not include near, or far-sightedness)
	_____	Bags, or dark circles under eyes
	_____	Swollen, reddened, or sticky eyes
		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
_____ Thinking about past
_____ Poor self-esteem
_____ No time for yourself
_____ Feeling of isolation
_____ Always feel like it is your fault
_____ Things never go your way

Total: _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total: _____

GRAND TOTAL: _____