



Arthritis Health

Comprehensive Care

Rheumatology • Naturopathy • Acupuncture • Yoga Therapy

Medical Symptoms Questionnaire

Name _____ Date _____

Rate symptoms based upon your health for:

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

- Sum each subsection and put in box

HEAD _____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia

EYES _____ Watery or itchy eyes
 _____ Swollen, reddened, or sticky eyelids
 _____ Bags or dark circles under eyes
 _____ Blurred or tunnel vision

EARS _____ Itchy ears
 _____ Earaches or ear infections
 _____ Drainage from ear
 _____ Ringing in ears or hearing loss

NOSE _____ Stuffy nose
 _____ Sinus problems
 _____ Hay fever
 _____ Sneezing attacks
 _____ Excessive mucus formation

MOUTH/THROAT
 _____ Chronic coughing
 _____ Gagging or need to clear throat
 _____ Sore throat, hoarseness, or loose voice
 _____ Swollen/discolored tongue, gums, lips
 _____ Canker sores

ENERGY/ACTIVITY
 _____ Fatigue or sluggishness
 _____ Apathy or lethargy
 _____ Hyperactivity
 _____ Restlessness

HEART _____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain

LUNGS
 _____ Chest congestion
 _____ Asthma or bronchitis
 _____ Shortness of breath
 _____ Difficulty breathing

DIGESTIVE TRACT

_____ Nausea or vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating feeling
 _____ Belching or passing gas
 _____ Heartburn
 _____ Intestinal/stomach pain

JOINTS/MUSCLE

_____ Pain or aches in joints
 _____ Arthritis
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Feeling of weakness or tiredness

WEIGHT

_____ Binge eating/drinking
 _____ Craving certain foods
 _____ Excessive weight
 _____ Compulsive eating
 _____ Water retention
 _____ Underweight

SKIN

_____ Acne
 _____ Hives, rashes, or dry skin
 _____ Flushing or hot flashes
 _____ Restlessness
 _____ Excessive sweating

MIND

_____ Poor memory
 _____ Confusion or poor comprehension
 _____ Poor Concentration
 _____ Poor physical coordination
 _____ Difficulty in making decisions
 _____ Stuttering or stammering
 _____ Slurred speech
 _____ Learning disabilities

EMOTIONS

_____ Mood swings
 _____ Anxiety, fear, or nervousness
 _____ Anger, irritability, or aggressiveness
 _____ Depression

OTHER

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

GRAND TOTAL