MEDICAL SYMPTOMS QUESTIONNAIRE / PATIENT HISTORY

Patient Name: _____ **Date:** _____

If you are currently involved in a health coaching process, answer for the time period dating back from your last health coach to the present day.

r Past week r Past 48 hours

Point Scale: 0 = *I never or almost never* have the symptom 1 = *I occasionally* have it, effect is *not severe* 2 = *I frequently* have it, effect is not *severe*
3 = *I occasionally* have it, effect is *severe* 4 = *I frequently* have it, effect is *severe*

Medical Symptoms Questionnaire (MSQ)

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 **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
_____ Chest pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat **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/ MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pain or aches in muscles **TOTAL** _____

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

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL** _____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
_____ Poor physical coordination **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 **TOTAL** _____