

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.

Past week Past 48 hours

Point Scale: **0** *I never or almost never* have the symptom
3 *I occasionally* have it, effect is severe

1 *I occasionally* have it, effect is not severe **2** *I frequently* have it, effect is not 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 discolor ed
 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
 _____ Bloating 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** _____