Clinical Revelation
Advanced Medical Testing and Functional Medicine Consultancy

# Medical Symptoms Questionnaire

**Patient Name**_____ **Date**_____

**Rate each of the following symptoms based upon your typical health profile for the past 14 days.**

**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 eyelids
_____ 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_____

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## 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
_____ 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:_____**

## Pre-Consultation Health Update:

In preparation for your upcoming appointment, please provide any info below that you feel may be relevant. For example,

- How you are getting on with health programme recommendations/supplements?
- Update of your health status overall
- Any questions that you have
- Anything that you'd especially like to focus on at your upcoming consultation.