Anita Sadaty, MD
Redefining Health

Thrive!

Medical Symptoms Questionnaire 1

Patient Name:_____ **Date:**_____

Rate Each Of The Following Symptoms Based Upon Your Typical Health Profile For The Past 14 Days:

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, 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 / Hearling Loss

Total:_____

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Medical Symptoms Questionnaire 2

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, effect is severe

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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Medical Symptoms Questionnaire 3

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, effect is severe

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: _____

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Medical Symptoms Questionnaire 4

Point Scale:

0 - Never or almost never have a symptom
1 - Occasionally have a symptom, effect is not severe
2 - Occasionally have a symptom, effect is severe
3 - Frequently have a symptom, effect is not severe
4 - Frequently have a symptom, effect is severe

ENERGY / ACTIVITY

_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness

Total: _____

MIND

_____ Poor Memory
_____ Poor Concentration
_____ Learning Disabilities
_____ Slurred Speach
_____ Confusion, Poor Comprehension
_____ Difficulty In Making Decisions
_____ Poor Physical Coordination
_____ Stuttering Or Stammering

Total: _____

EMOTIONS

_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression

Total: _____

OTHER

_____ Frequent Illness
_____ Frequent Or Urgent Urination
_____ Genital Itch Or Discharge

Total: _____

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