THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name _____ *Date* _____

Instructions

Use this point scale to rate each of the following symptoms based on 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 (doesn't include nearsightedness or farsightedness)
_____ **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**

Please continue on the next page

Point scale (rate symptoms over 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

Mouth and 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**

Lungs

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ **Total**

Digestive Tract

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal or stomach pain
_____ **Total**

Joints and Muscles

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

Please continue on the next page

Point scale (rate symptoms over 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

Weight

_____ Binge eating or drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ **Total**

Energy or 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 (for all sections)**