My Symptom Questionnaire (MySQ)

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:
0 = Never
1 = Occasionally, Effect not severe
2 = Occasionally, Effect severe
3 = Frequently, Effect not severe
4 = Frequently, Effect severe

Head

Headaches		Faintness	
Dizziness			

Total

Nose

Stuffy nose		Sinus problems	
Hay fever		Sneezing attacks	
Excessive mucus formation		Loss sense of smell	

Total

Nails

Spoon shaped		Brittle, cracking	
Discolored		White spots	
Lines/Stripes			

Total

Hair

Hair thinning		Hair loss	
Loss of outer eyebrow hair		Premature greying	

Total

Skin

Acne		Hives, rashes	
Dry skin		Bumps on back of arms	
Flushing		Excessive sweating	

Total

Genitourinary

Frequent or urgent urination		Itching	
Discharge		Incontinence	

Total

Eyes

Watery/itchy eyes		Yellowing eyes	
Swollen, reddened, sticky eyelids		Bags, dark circles	
Night vision problems		Blurred vision	
Loss peripheral vision			

Total

Mouth/Throat

Chronic coughing		Gagging frequently, throat clearing	
Sore throat		Hoarseness	
Swollen/discolored tongue		Burning tongue	
Coating on tongue		Chewing problems	
Canker Sores		Fever blisters	
Cracks corner of mouth			

Total

Heart

Irregular/skipped beats		Rapid/ pounding beats	
Chest Pain			

Total

Lungs

Chest Congestion		Asthma or bronchitis	
Shortness of breath		Difficulty Breathing	

Total

Energy/Sleep

Fatigue		Lethargy	
Hyperactivity		Insomnia	
Sleep disruptions			

Total

Neurological

Poor memory		Confusion	
Poor concentration/“brain fog”		Poor physical coordination	
Loss of balance		Tingling in hands or feet	
Stuttering or stammering		Slurred speech	

Total

Ears

Itchy Ears		Ear aches, ear infections	
Drainage from ear		Ringing	
Hearing loss			

Total

Digestive Tract/Gastrointestinal (GI)

Nausea		Vomiting	
Diarrhea		Constipation	
Alternating diarrhea & constipation		Bloating	
Belching		Gas/flatulence	
Heartburn		Upper GI pain	
Lower abdominal pain			

Total

Joints/Muscle/Bone

Pain or aches in joints		Arthritis	
Stiffness/limited movement		Pain or aches in muscles	
Feeling of weakness or loss of strength		Restless legs	
Bone pain		Broken bones	

Total

Weight

Underweight		Overweight	
Obese		Weight loss (>5-10 lbs)	
Weight gain (>5-10 lbs)		Fluid retention	
Binge eating or drinking		Craving certain foods	

Total

Emotions

Mood Swings		Anxiety, worry, fear, nervousness	
Anger, irritability, agitation		Depression	

Total

Key: the higher the score, the greater the impact on the individual.

- 0-15 Fair
- 16-25 Moderate
- 26-50 Major
- >50 Severe

Grand Total	