AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH

Produced in collaboration with Loma Linda University

Medical Symptom Questionnaire

GETTING STARTED

			Very poor health										Excellent health
a.	Please circle your current overall **LEVEL OF HEALTH**.	0	0	1	2	3	4	5	6	7	8	9	10

b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.

Sleep ☐	Weight Management ☐	Nutrition ☐
Exercise ☐	Purpose & Connection ☐	Mental Health ☐
Substance Use ☐		

			Not important at all										Very important
c.	How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?	0	0	1	2	3	4	5	6	7	8	9	10
d.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?	0	0	1	2	3	4	5	6	7	8	9	10
e.	How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?	0	0	1	2	3	4	5	6	7	8	9	10
f.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?	0	0	1	2	3	4	5	6	7	8	9	10
g.	How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?	0	0	1	2	3	4	5	6	7	8	9	10
h.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address?	0	0	1	2	3	4	5	6	7	8	9	10

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

☐ More medical/scientific knowledge	☐ Practical health tips	☐ Other: _____
☐ Accountability	☐ Personalized plan	

Patient Name:_____ DOB: _____

MEDICAL SYMPTOM QUESTIONNAIRE (MSQ)

This questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the **PAST 30 DAYS**. If you are taking after the first time, record your symptoms for the LAST 48 HOURS ONLY.

Point Scale

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE							
Diarrhea	0	0	1	2	3	4	
Constipation	0	0	1	2	3	4	
Bloated feeling	0	0	1	2	3	4	
Belching, passing gas	0	0	1	2	3	4	
Heartburn	0	0	1	2	3	4	
Intestinal/stomach pain	0	0	1	2	3	4	
Nausea or vomiting	0	0	1	2	3	4	
Total points							0
EARS							
Itchy ears	0	0	0	1	2	3	
Earaches, ear infections	0	0	1	2	3	4	
Drainage from ear	0	0	1	2	3	4	
Ringing in ears, hearing loss	0	0	1	2	3	4	
Total points							0
HEAD							
Headaches	0	0	1	2	3	4	
Faintness or lightheadedness	0	0	1	2	3	4	
Dizziness	0	0	1	2	3	4	
Insomnia	0	0	1	2	3	4	
Total points							0
HEART							
Irregular or skipped heartbeat	0	0	1	2	3	4	
Chest pain	0	0	1	2	3	4	
Rapid or pounding heartbeat	0	0	1	2	3	4	
Total points							0
JOINTS/MUSCLES							
Pains or aches in joints	0	0	1	2	3	4	
Arthritis	0	0	1	2	3	4	
Stiffness or limitations of movement	0	0	1	2	3	4	
Pain or aches in muscles	0	0	1	2	3	4	
Feeling of weakness or tiredness	0	0	1	2	3	4	
Total points							0
LUNGS							
Chest congestion	0	0	1	2	3	4	
Asthma, bronchitis	0	0	1	2	3	4	
Shortness of breath	0	0	1	2	3	4	
Difficulty breathing	0	0	1	2	3	4	
Total points							0
MIND							
Poor memory	0	0	1	2	3	4	
Confusion, poor comprehension	0	0	1	2	3	4	
Poor concentration	0	0	1	2	3	4	
Poor physical coordination	0	0	1	2	3	4	
Difficulty making decisions	0	0	1	2	3	4	
Stuttering or stammering	0	0	1	2	3	4	
Learning disabilities	0	0	1	2	3	4	
Slurred speech	0	0	1	2	3	4	
Total points							0

EMOTIONS							
Mood swings	0	0	1	2	3	4	
Anxiety, fear, nervousness	0	0	1	2	3	4	
Anger, irritability, aggressiveness	0	0	1	2	3	4	
Depression	0	0	1	2	3	4	
Total points							0
ENERGY/ACTIVITY							
Fatigue, sluggishness	0	0	1	2	3	4	
Apathy, lethargy	0	0	1	2	3	4	
Hyperactivity	0	0	1	2	3	4	
Restlessness	0	0	1	2	3	4	
Total points							0
EYES							
Watery or itchy eyes	0	0	1	2	3	4	
Swollen, reddened or sticky eyelids	4	0	1	2	3	4	
Bags or dark circles under eyes	0	0	1	2	3	4	
Blurred or tunnel vision *(does not include near or far sightedness)*	0	0	1	2	3	4	
Total points							4
NOSE							
Stuffy nose	0	0	1	2	3	4	
Sinus problems	0	0	1	2	3	4	
Sneezing attacks	0	0	1	2	3	4	
Excessive mucous formation	0	0	1	2	3	4	
Hay fever	0	0	1	2	3	4	
Total points							0
SKIN							
Acne	0	0	1	2	3	4	
Hives, rashes, dry skin	0	0	1	2	3	4	
Hair loss	0	0	1	2	3	4	
Flushing or hot flushes	0	0	1	2	3	4	
Excessive sweating	0	0	1	2	3	4	
Total points							0
WEIGHT							
Binge eating/drinking	0	0	1	2	3	4	
Craving certain foods	0	0	1	2	3	4	
Excessive weight	0	0	1	2	3	4	
Water retention	0	0	1	2	3	4	
Underweight	0	0	1	2	3	4	
Compulsive eating	0	0	1	2	3	4	
Total points							0
OTHER							
Frequent illness	0	0	1	2	3	4	
Frequent or urgent urination	0	0	1	2	3	4	
Genital itch or discharge	0	0	1	2	3	4	
Total points							0
GRAND TOTAL							4

KEY: Add individual scores and total each group. Add each group score to give a grand total.
*Optimal is <10; Mild Symptoms: 10-50; Moderate Symptoms: 50-100; Severe Symptoms: over 100

Patient Name:_____ DOB: _____