# REVIEW OF MEDICAL SYMPTOMS ADULT

Name: _____ Date: _____ DOB: _____

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

Point Scale:
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*

| **General** | *Points* |
|---|---|
| Weight loss/Underweight | |
| Weight Gain/ Excessive Weight | |
| Night Sweats | |
| Headaches | |
| Fatigue | |
| Frequent illness* | |

Total _____

| **Skin** | *Points* |
|---|---|
| Rash | |
| Hives/Itching | |
| Hair loss/Change in hair or nails | |
| Dry skin | |
| Acne* | |
| Flushing or hot flashes* | |

Total _____

| **Allergy/Immune** | *Points* |
|---|---|
| Reaction to food | |
| Seasonal allergies | |
| Excessive mucous | |
| Cancer | |

Total _____

| **Ear/Nose/Throat** | *Points* |
|---|---|
| Hearing loss or ringing in ears | |
| Earache or ear infection | |
| Drainage from ear | |
| Hoarseness | |
| Nasal congestion | |
| Sinus problems/Sinusitis | |
| Mouth sore/Canker sore | |
| Sore throat | |
| Sneezing attacks* | |
| Swollen tongue, gums, lips* | |
| Itchy ears* | |
| Gagging/Frequent need to clear throat* | |

Total _____

| **Head/Eyes** | *Points* |
|---|---|
| Head Injury | |
| Eye disease or injury | |
| Vertigo/Dizziness | |
| Lightheaded/Faintness | |
| Tearing or itchy eyes | |
| Blind spots or tunnel vision | |
| Swollen, red, sticky eyelids* | |
| Bags or dark circles under the eyes | |

Total _____

| **Heart** | *Points* |
|---|---|
| Chest Pain | |
| Shortness of breath/Dyspnea | |
| Palpitation/Rapid or pounding heart beat | |
| Edema/Swelling of feet, ankles, or hands | |
| Syncope or fainting | |
| Irregular heart beat | |

Total _____

| **Lungs** | *Points* |
|---|---|
| Dry cough | |
| Recurring colds or bronchitis | |
| Productive cough | |
| Asthma or wheezing | |
| Stridor or difficulty breathing | |
| Chest congestion* | |

Total _____

| **Digestion** | *Points* |
|---|---|
| Nausea or vomiting | |
| Diarrhea | |
| Rectal bleeding or blood in stool | |

| | |
|---|---|
| Dysphagia or trouble swallowing | |
| Flatulence | |
| Abdominal pain | |
| Indigestion/Bloated feeling | |
| Heartburn | |
| Constipation | |
| Burping or belching | |

Total _____

| **Musculoskeletal** | *Points* |
|---|---|
| Pain or aches in joints | |
| Weakness | |
| Muscle pain or ache | |
| Stiffness or limitation of movement | |
| Night cramps | |
| Back pain | |
| Arthritis* | |

Total _____

| **Neurologic** | *Points* |
|---|---|
| Loss of memory | |
| Difficulty with speech – stutter or slurred | |
| Uncoordination | |
| Confusion* | |
| Difficulty making decisions* | |
| Learning disability* | |

Total _____

| **Mental and Physical Energy** | *Points* |
|---|---|
| Depression | |
| Insomnia | |
| Anxiety or fear | |
| Mood swings* | |
| Anger, irritability* | |
| Apathy or lethargy* | |
| Hyperactivity* | |
| Restlessness* | |

Total _____

| **Dietary** | *Points* |
|---|---|
| Binge eating or drinking* | |
| Craving certain foods* | |
| Compulsive Eating* | |
| Water Retention* | |

Total _____

**Grand Total**_____

Additional Symptoms Review:

| **Male** | *Points* |
|---|---|
| Urgency of urination | |
| Frequent urination | |
| Difficult urination | |
| Sexual difficulty | |
| Testicular pain or swelling | |
| Genital sores | |
| Hematuria or blood in urine | |
| Nocturnal – urinating more than once at night | |

| **Female** | *Points* |
|---|---|
| Urgency of urination | |
| Frequent urination | |
| Dysuria/Pain with urination | |
| Urinary incontinence | |
| Hematuria or blood in urine | |
| Vaginal discharge or itching | |
| Painful periods/Cramps | |
| Irregular periods | |
| Genital sores | |
| Sexual difficulty | |

| **Endocrine** | *Points* |
|---|---|
| Cold intolerance | |
| Goiter/Enlarged thyroid | |
| Hormone problem or therapy | |
| Diabetes | |

| **Blood/Lymphatic** | *Points* |
|---|---|
| Easy bruising | |
| Swollen glands | |