Modified Medical Symptoms Questionnaire (MMSQ) V2

Name _____ **Date** _____

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

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*

HEAD

_____ Migraine
_____ Headache
_____ Dizziness
_____ Faintness Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes Total _____

NOSE

_____ Stuffy nose
_____ Runny nose
_____ Itchy nose
_____ Sneezing Total _____

MOUTH/THROAT

_____ Mouth ulcers/ mouth sores
_____ Redness/ cracking in the corner of the mouth
_____ Tongue soreness
_____ Dry/ cracked lips
_____ Bleeding gums Total _____

SKIN

_____ Acne
_____ Dry, red, or cracked
_____ Hives, rashes
_____ Easily bruised Total _____

LUNGS

_____ Cough/ wheeze
_____ Shortness of breath
_____ Chest tightness Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Heartburn
_____ Intestinal/stomach pain Total _____

JOINTS / MUSCLE

_____ Persistent/ constant pain
_____ Bone pain /ache/ tenderness
_____ Joint pain /ache/ tenderness
_____ Muscle pain /ache/ tenderness
_____ Weakness
_____ Numbness/ pins and needles
_____ Morning stiffness
_____ Daytime stiffness
_____ Cramps/ twitching
_____ Tremor Total _____

ENERGY / ACTIVITY

_____ Fatigue, sluggishness
_____ Insomnia/ problems sleeping Total _____

EMOTIONS

_____ Anxiety, fear, nervousness
_____ Depression Total _____

OTHER

_____ Frequent illness
_____ PMS
Total _____

GRAND TOTAL ***TOTAL*** **_____/ 180**