Cell Science Systems	**TITLE:** **MEDICAL SYMPTOM QUESTIONNAIRE**	*REV. IL2015*

NAME/ID: _____ **Collection Date** _____ **Grand Total** _____

Point Scale: *Rate each of the following symptoms based upon your typical health profile for the past 30 days*

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

DIGESTIVE TRACT		***WEIGHT***		***JOINTS/MUSCLE***	
Nausea, vomiting	____	Binge eating/drinking	____	Pain or aches in joints	____
Diarrhea	____	Craving certain foods	____	Arthritis	____
Constipation	____	Excessive weight	____	Stiffness or limitation of	____
Bloated feeling	____	Compulsive eating	____	movement	
Belching, passing gas	____	Water retention	____	Pain or aches in muscles	____
Heartburn	____	Underweight	____	Feeling of weakness or	____
Intestinal/stomach pain	____			tiredness	____
TOTAL	____	**TOTAL**	____	**TOTAL**	____
HEART		***LUNGS***		***ENERGY/ACTIVITY***	
Irregular or skipped	____	Chest congestion	____	Fatigue, sluggishness	____
heartbeat	____	Asthma, bronchitis	____	Apathy, lethargy	____
Rapid or pounding heartbeat	____	Shortness of breath	____	Hyperactivity	____
Chest pain	____	Difficulty breathing	____	Restlessness	____
TOTAL	____	**TOTAL**	____	**TOTAL**	____
EARS		***MOUTH/THROAT***		***NOSE***	
Itchy ears	____	Chronic coughing	____	Stuffy nose	____
Earaches, ear infections	____	Gagging, frequent need to	____	Sinus problems	____
Drainage from ear	____	clear throat		Hay fever	____
Ringing in ears, hearing loss	____	Sore throat, hoarseness, loss of	____	Sneezing attacks	____
		voice		Excessive mucus	____
		Swollen or discolored tongue,	____	formation	
		gums, lips			
		Canker sores	____		
TOTAL	____	**TOTAL**	____	**TOTAL**	____
MIND		***HEAD***		***EYES***	
Poor memory	____	Headaches	____	Watery or itchy eyes	____
Confusion, poor	____	Faintness	____	Swollen, reddened or	____
comprehension	____	Dizziness	____	sticky eyelids	____
Poor concentration	____	Insomnia	____	Bags or dark circles	____
Poor physical coordination	____			under eyes	____
Difficulty in making	____			Blurred or tunnel vision	____
decisions				(does not include near or	
Stuttering or stammering	____			far-sightedness)	
Slurred speech	____				
Learning disabilities	____				
TOTAL	____	**TOTAL**	____	**TOTAL**	____
SKIN		***EMOTIONS***		***OTHER***	
Acne	____	Mood swings	____	Frequent illness	____
Hives, rashes, dry skin	____	Anxiety, fear, nervousness	____	Frequent or urgent	____
Hair loss	____	Anger, irritability,	____	urination	____
Flushing, hot flashes	____	aggressiveness	____	Genital itch or discharge	____
Excessive sweating	____	Depression	____		____
TOTAL	____	**TOTAL**	____	**TOTAL**	____

Health Key: Optimal: <10 Suboptimal: 10-50 Poor: 50-100 Extremely Poor: >100