BIOSIS HEALTHCARE

Mini - Consult ~ Medical Symptoms Questionnaire (MSQ)

Patient Name _____ Date _____

Address:_____ Apt # _____

City:_____ Postal Code:_____

Telephone _____ E - mail:_____

Age:_____ Sex:_____ Height:_____ Weight:_____

Rate each of the following symptoms based upon your typical health profile for the past 90 days on the 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

	Visit #	1st	2nd	3rd		Total	1st	2nd	3rd
HEAD		___	___	___	Headaches				
		___	___	___	Faintness				
		___	___	___	Dizziness				
		___	___	___	Insomnia	Total	___	___	___
EYES		___	___	___	Watery or itchy eyes				
		___	___	___	Swollen, reddened or sticky eyelids				
		___	___	___	Bags or dark circles under eyes				
		___	___	___	Blurred or tunnel vision (does not include near- or far-sightedness)	Total	___	___	___
EARS		___	___	___	Itchy ears				
		___	___	___	Earaches, ear infections				
		___	___	___	Drainage from ear				
		___	___	___	Ringing in ears, hearing loss	Total	___	___	___
NOSE		___	___	___	Stuffy nose				
		___	___	___	Sinus problems				
		___	___	___	Hay fever				
		___	___	___	Sneezing attacks				
		___	___	___	Excessive mucus formation	Total	___	___	___
MOUTH/ THROAT		___	___	___	Chronic coughing				
		___	___	___	Gagging, frequent need to clear throat				
		___	___	___	Sore throat, hoarseness, loss of voice				
		___	___	___	Swollen or coated tongue, gums, lips				
		___	___	___	Canker sores	Total	___	___	___
SKIN		___	___	___	Acne				
		___	___	___	Hives, rashes, dry skin				
		___	___	___	Hair loss				
		___	___	___	Flushing, hot flashes				
		___	___	___	Excessive sweating	Total	___	___	___
HEART		___	___	___	Irregular, rapid or skipped heartbeat				
		___	___	___	High blood pressure				
		___	___	___	High cholesterol	Total	___	___	___

LUNGS	___	___	___	Chest congestion	Total	1st	2nd	3rd
	___	___	___	Asthma, bronchitis				
	___	___	___	Shortness of breath				
	___	___	___	Difficulty breathing	Total	___	___	___
DIGESTIVE TRACT	___	___	___	Nausea, vomiting				
	___	___	___	Diarrhea				
	___	___	___	Constipation				
	___	___	___	Bloated feeling				
	___	___	___	Belching, passing gas				
	___	___	___	Heartburn				
	___	___	___	Intestinal/stomach pain	Total	___	___	___
JOINTS/ MUSCLE	___	___	___	Pain or aches in joints				
	___	___	___	Arthritis				
	___	___	___	Stiffness or limitation of movement				
	___	___	___	Pain or aches in muscles				
	___	___	___	Feeling of weakness or tiredness	Total	___	___	___
WEIGHT	___	___	___	Binge eating/drinking				
	___	___	___	Craving certain foods				
	___	___	___	Excessive weight				
	___	___	___	Compulsive eating				
	___	___	___	Water retention				
	___	___	___	Underweight	Total	___	___	___
ENERGY/ ACTIVITY	___	___	___	Fatigue, sluggishness				
	___	___	___	Apathy, lethargy				
	___	___	___	Hyperactivity				
	___	___	___	Restlessness	Total	___	___	___
MIND	___	___	___	Poor memory				
	___	___	___	Confusion, poor comprehension				
	___	___	___	Poor concentration				
	___	___	___	Poor physical coordination				
	___	___	___	Difficulty in making decisions				
	___	___	___	Stuttering or stammering				
	___	___	___	Slurred speech				
	___	___	___	Learning disabilities	Total	___	___	___
EMOTIONS	___	___	___	Mood swings				
	___	___	___	Anxiety, fear, nervousness				
	___	___	___	Anger, irritability, aggressiveness				
	___	___	___	Depression	Total	___	___	___
OTHER	___	___	___	Frequent illness				
	___	___	___	Frequent or urgent urination				
	___	___	___	Genital itch or discharge	Total	___	___	___
					GRAND TOTAL	___ 1st	___ 2nd	___ 3rd

Once you have filled and scored your results; please mail, fax, scan or e-mail your results to:
Biosis Healthcare; 42 Bridgenorth Cresent; Etobicoke, ON. M9V 2M3 clinic: 416-519-7599 fax: 416-551-7515
email: info@biosishealthcare.com