

Multi Symptom Questionnaire

0: never

1: occasionally/in the past

2: frequently

3: (almost) constantly

General

- Feeling unwell
- Lack of energy or sluggishness
- Weakness
- Fatigue
- Unexplained fever
- Recent or recurrence of illness
- Excessive weight gain
- Excessive weight loss
- Worse in hot conditions
- Worse in cold conditions
- Worse in damp conditions

Eyes

- Wearing glasses or contact lenses
- Specks or floaters
- Flashing lights
- Blurred or double vision
- Narrowed visual field or tunnel vision
- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Eye pain
- Discharge
- Bags or dark circles under eyes

Ears

- Hearing loss or blocked ears
- Earaches
- Ear infections
- Discharge
- Tinnitus (ringing or buzzing in the ears)
- Itchy ears

Nose

- Frequent colds
- Stuffy nose or nasal discharge
- Sinus infections or sinus congestion
- Hayfever or sneezing attacks
- Post-nasal drip or excessive mucus
- Nosebleeds
- Loss of smell

Mouth and throat

- Sore throat
- Hoarseness
- Loss of voice
- Tonsillitis
- Gagging or difficulty swallowing
- Loss of taste or smell
- Chronic coughing or clearing of throat
- Dry mouth
- Swollen, sore or discoloured tongue
- Cold sores
- Sore or cracked lips
- Bleeding gums
- Receding gums
- Mouth ulcers
- Infected teeth or abscesses
- Missing teeth
- Unattended cavities
- Mercury fillings
- Root canal fillings
- Dentures

Cardiovascular (heart and blood)

- Rapid/racing or pounding heart beat
- Irregular or skipped heart beat
- High blood pressure
- Low blood pressure
- High cholesterol
- Chest pains
- Angina
- Anaemia
- Cold hands and feet
- Swollen ankles (oedema)
- Blueness of skin
- Bruising easily
- Bleeding easily
- Blood clots
- Leg or calf pain or tenderness
- Varicose veins
- Deep vein thrombosis (DVT)



Respiratory (lungs)

- Chest pain or tightness
- Chest congestion or productive cough
- Dry or hacking cough
- Coughing up blood
- Shortness of breath or difficulty breathing
- Wheezing or asthma
- Excessive expectoration (sputum/mucous)
- Recurrent or chronic bronchitis
- Pneumonia
- Emphysema

Gastrointestinal (digestion)

- Changes in appetite
- Heartburn – episodic or recurrent
- Reflux
- Indigestion
- Difficulty swallowing
- Episodic nausea or vomiting
- Binge eating/drinking or compulsive eating
- Bad breath
- Coated tongue
- Belching or burping
- Bloating – episodic or recurrent
- Flatulence or passing gas
- Fullness after meals
- Food cravings (please list):
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.....
- Abdominal pain, cramps or discomfort
- Intolerant of fatty foods
- Use of antacids or proton pump inhibitors
- Constipation
- Incomplete emptying
- Diarrhoea
- Change in bowel habits
- Ulcers
- Jaundice
- Pale/yellow stools
- Mucus in stools
- Black or tarry stools
- Haemorrhoids
- Rectal bleeding
- Rectal/anal fissures
- Anal itching

Musculo-skeletal (joints & muscles)

- Joint pain, aches or soreness
- Joint stiffness or limitation of movement
- Joint swelling
- Muscle aches or pains
- Muscle cramps or spasms
- Muscle weakness or heaviness
- Loss of muscle bulk
- Bone pain or feeling of bruising
- Bad posture
- Back pain
- Broken bones
- Injuries
- Deformities
- Numbness or tingling

Genito-urinary (kidneys & genitalia)

- Frequent or urgent urination
- Urination at night
- Pain on urination
- Blood in urine
- Incontinence
- Incomplete emptying
- Urinary tract infections (UTIs) or cystitis
- Dark coloured urine
- Foul smelling urine
- Loss of libido
- Infertility
- Genital itch
- Genital discharge
- Genital warts
- Genital sores or abscesses
- Sexually transmitted disease (please list):
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Men

- Prostate problems
- Hesitant flow
- Diminished flow
- Dribbling
- Pain in testicles
- Swollen testicles
- Inability to achieve erection
- Inability to maintain erection
- Pain during intercourse
- Date of last prostate exam?

Women

- Pain during menstruation
- Heavy menstrual flow
- Scanty menstrual flow
- Irregular menses
- Absence of menstruation
- Bleeding between periods
- Hot flushes
- Night sweats
- Breast tenderness or soreness
- Lumps or cysts in the breast
- Premenstrual syndrome (PMS)
- Pain during intercourse
- Oral contraceptive pill use
- Intra-uterine device (IUD) use
- Hormone replacement therapy (HRT) use

	Yes	No
Pregnancies (how many?)	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage (how many?)	<input type="checkbox"/>	<input type="checkbox"/>
Terminations (how many?)	<input type="checkbox"/>	<input type="checkbox"/>
Caesarean (how many?)	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic ovarian syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
If menopausal or perimenopausal?	<input type="checkbox"/>	<input type="checkbox"/>
Please list symptoms and concerns:.....		
.....		
Date of last PAP smear?		

If still menstruating:

Age of onset of first menses?

Periods lastdays and occur everydays

Date of last period?

Bleeding is..... heavy..... moderate..... light

Endocrine

- Excessive thirst
- Excessive hunger
- Needing meals on time
- Excessive sweating
- Feeling sluggish
- Dizziness on rising
- Hyperactivity or restlessness
- Extreme emotional lability
- Fine tremors

Neurological (brain, nerves and cognition)

- Dizziness or vertigo
- Fainting or blackouts
- Abnormal involuntary movements or tremors
- Numbness or loss of sensation
- Tingling/crawling sensation
- Pins and needles
- Shooting or radiating pain
- Facial twitching
- Weakness or heaviness of a limb
- Restless or fidgety legs
- Sensitivity to light
- Sensitivity to noise
- Unsteady gait or loss of balance
- Headaches
- Migraines
- Seizures or fits
- Paralysis
- Speech problems
- Poor memory
- Poor concentration
- Poor comprehension/confusion or mental fog

Emotions and feelings

- Mood swings
- Depression
- Anxiety
- Nervousness
- Excessive worry
- Fear
- Anger or aggressiveness
- Feeling overwhelmed or unable to cope
- Suicidal thoughts
- Lack of self esteem
- Irritability
- Recurring thoughts
- Other (please list):

Sleep

- Difficulty falling asleep
- Difficulty staying asleep
- Unrefreshed sleep or tired on waking
- Unable to remember dreams
- Nightmares or disturbing dreams
- Snoring

Skin

- Rash
- Lumps
- Sores
- Eczema or dermatitis
- Acne
- Psoriasis
- Itching
- Dryness
- Colour or texture change of spots
- Mottling, blotching or pigmentation
- Lack of elasticity
- Tinea or ringworm
- Warts

Hair

- Falling out
- Breaking/splitting
- Oily
- Dry
- Lustreless
- Excessive hair growth

Nails

- Soft
- Brittle
- Splitting

Immunity

- Frequent colds
- Frequent influenza
- Frequent infections
- Slow wound healing
- Viral infections
 - Ross River
 - Barmah Forest
 - Cytomegalovirus
 - Epstein-Barr (Glandular fever)
- Swollen lymph nodes
 - Neck
 - Under arms
 - In groin
- Allergies general
 - Hayfever
 - Hives
 - Eczema

- Allergies to environment
 - Pollen
 - House dust
 - Dust mite
 - Animal fur/feathers
 - Other
- Food allergies/sensitivities/intolerances
 - Dairy
 - Wheat/gluten
 - Fish
 - Shellfish
 - Eggs
 - Pork
 - Chicken
 - Citrus
 - Other fruit
 - Vegetables
 - Nuts (tree)
 - Peanuts
 - Soy
 - Caffeine-containing food or drinks
 - MSG

- Allergies to drugs (please list)
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 -
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- Specific allergies/sensitivities/intolerances not listed above:
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 -
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Toxin exposure

- Paint/paint fumes
- Agricultural chemicals (eg. insecticides, herbicides)
- Laboratory chemicals (esp. organic solvents)
- Petrol fumes
- Cigarette smoke
- Corrosive agents
- Gas
- Metals
- Other (please list):
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Do you have or have you had any of the following:

	Yes	No
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Haemachromatosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus		
Type I	<input type="checkbox"/>	<input type="checkbox"/>
Type II	<input type="checkbox"/>	<input type="checkbox"/>
Gestational	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Goitre	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease, stones or infection	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Liver damage or fatty liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
Coeliac disease	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse or drug addiction	<input type="checkbox"/>	<input type="checkbox"/>
Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Genetic abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Gum disease	<input type="checkbox"/>	<input type="checkbox"/>
HIV exposure	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorders (eg.):		
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>

Cancer

Melanoma or other skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma or leukaemia	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or colon	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian or uterine	<input type="checkbox"/>	<input type="checkbox"/>
Cervical	<input type="checkbox"/>	<input type="checkbox"/>

Infections

Malaria	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Mycoplasma	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough (pertussis)	<input type="checkbox"/>	<input type="checkbox"/>
Yeast infections (eg. Candida)	<input type="checkbox"/>	<input type="checkbox"/>
Herpes		
Zoster (chickenpox)	<input type="checkbox"/>	<input type="checkbox"/>
Simplex	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal (eg.)		
Salmonella	<input type="checkbox"/>	<input type="checkbox"/>
Giardia	<input type="checkbox"/>	<input type="checkbox"/>
Blastocystis	<input type="checkbox"/>	<input type="checkbox"/>
Campylobacter	<input type="checkbox"/>	<input type="checkbox"/>
Shigella	<input type="checkbox"/>	<input type="checkbox"/>
Listeria	<input type="checkbox"/>	<input type="checkbox"/>
Parasitic worms	<input type="checkbox"/>	<input type="checkbox"/>

Other (please list):

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Vaccinations for:

Childhood illnesses	<input type="checkbox"/>	<input type="checkbox"/>
Travel	<input type="checkbox"/>	<input type="checkbox"/>
Work related	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any surgery? Please list:

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Is there anything else you would like to add?

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