



# Functional and Integrative Medicine of McCall

## REVIEW OF MEDICAL SYMPTOMS

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	
Nightsweats	
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	

<b>Musculoskeletal</b>	<i>Points</i>
Pain or aches in joints	
Weakness	
Muscle pain or ache	
Stiffness or limitation of movement	
Night cramps	
Back pain	
Arthritis*	
Total _____	

<b>Mental and Physical Energy</b>	<i>Points</i>
Depression	
Insomnia	
Anxiety or fear	
Mood swings*	
Anger, irritability*	
Apathy or lethargy*	
Hyperactivity*	
Restlessness*	
Total _____	

<b>Neurologic</b>	<i>Points</i>
Loss of memory	
Difficulty with speech – stutter or slurred	
Uncoordination	
Confusion*	
Difficulty making decisions*	
Learning disability*	
Total _____	

<b>Dietary</b>	<i>Points</i>
Binge eating or drinking*	
Craving certain foods*	
Compulsive Eating*	
Water Retention*	
Total _____	

**Grand Total** \_\_\_\_\_

Additional Symptoms Review:

<b>Male</b>	<i>Points</i>
Urgency of urination	
Frequent urination	
Difficult urination	
Sexual difficulty	
Testicular pain or swelling	
Genital sores	
Hematuria or blood in urine	
Nocturia – urinating more than once at night	

<b>Endocrine</b>	<i>Points</i>
Cold intolerance	
Goiter/Enlarged thyroid	
Hormone problem or therapy	
Diabetes	

<b>Female</b>	<i>Points</i>
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	

<b>Blood/Lymphatic</b>	<i>Points</i>
Easy bruising	
Swollen glands	