First Name: **Surname:** **Todays date:**

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?)	☐	☐
Miscarriage (how many?)	☐	☐
Terminations (how many?)	☐	☐
Caesarean (how many?)	☐	☐
Hysterectomy	☐	☐
Polycystic ovarian syndrome	☐	☐
Ovarian cysts	☐	☐
Uterine fibroids	☐	☐
Endometriosis	☐	☐
If menopausal or perimenopausal?	☐	☐

Please list symptoms and concerns:.....

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Date of last PAP smear? .....

If still menstruating:

Age of onset of first menses? .....

Periods last .....days and occur every .....days

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):

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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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- ☐ Specific allergies/sensitivities/ intolerances not listed above:

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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	☐	☐
Rheumatic fever	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Haemachromatosis	☐	☐
Blood transfusions	☐	☐
Stroke	☐	☐
Diabetes mellitus		
Type I	☐	☐
Type II	☐	☐
Gestational	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Thyroid disease	☐	☐
Goitre	☐	☐
Kidney disease, stones or infection	☐	☐
Hepatitis	☐	☐
Liver damage or fatty liver disease	☐	☐
Crohn's disease	☐	☐
Ulcerative colitis	☐	☐
Coeliac disease	☐	☐
Gall stones	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
Gout	☐	☐
Epilepsy	☐	☐
Psychiatric illness	☐	☐
Eating disorder	☐	☐
Substance abuse or drug addiction	☐	☐
Nervous breakdown	☐	☐
Attempted suicide	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Multiple sclerosis	☐	☐
Chronic Fatigue Syndrome	☐	☐
Fibromyalgia	☐	☐
Genetic abnormalities	☐	☐
Gum disease	☐	☐
HIV exposure	☐	☐
Autoimmune disorders (eg.):		
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus (SLE)	☐	☐
Cancer		
Melanoma or other skin cancer	☐	☐
Breast	☐	☐
Lung	☐	☐
Lymphoma or leukaemia	☐	☐
Stomach or colon	☐	☐
Ovarian or uterine	☐	☐
Cervical	☐	☐
Infections		
Malaria	☐	☐
Tuberculosis (TB)	☐	☐
Mycoplasma	☐	☐
Tetanus	☐	☐
Lyme disease	☐	☐
Polio	☐	☐
Whooping cough (pertussis)	☐	☐
Yeast infections (eg. Candida)	☐	☐
Herpes		
Zoster (chickenpox)	☐	☐
Simplex	☐	☐
Gastrointestinal (eg.)		
Salmonella	☐	☐
Giardia	☐	☐
Blastocystis	☐	☐
Campylobacter	☐	☐
Shigella	☐	☐
Listeria	☐	☐
Parasitic worms	☐	☐
Other (please list):		
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Vaccinations for:		
Childhood illnesses	☐	☐
Travel	☐	☐
Work related	☐	☐
Influenza	☐	☐

Have you had any surgery? Please list:

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Is there anything else you would like to add?

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