Internal Medicine &
Center for Medical Weight Loss

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Medical Symptoms / Review of Systems

Name ______________________________ Date ____________ Week __________

Rate each of the following symptoms based upon your typical health profile for: ❑ Past 30 days ❑ Past 48 hours

Point Scale	
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	

HEAD
____ Headaches
____ Faintness
____ Faintness
____ Dizziness
____ Faintness
____ 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 farsightedness)
____ TOTAL

MOUTH/ THROAT
____ Chronic Coughing
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums or lips
____ Canker sores
____ TOTAL

NOSE
____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucus formation
____ TOTAL

EARS
____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears, hearing loss
____ TOTAL

SKIN
____ Acne
____ Hives, rashes, dry skin
____ Hair loss
____ Flushing, hot flashes
____ Excessive Sweating
____ TOTAL

HEART
____ Irregular or skipped heartbeat
____ Rapid or pounding heartbeat
____ Chest Pain
____ TOTAL

JOINTS / MUSCLES
____ Pain or aches in joints
____ Arthritis
____ Stiffness or limitation of movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness
____ TOTAL

DIGESTIVE TRACT
____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal/stomach pain
____ TOTAL

LUNGS
____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing
____ 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

____

My goals and chief concerns are: ____

____

My Challenges: ____

____

Balanced Eating

List how many servings of each food groups you eat daily:

Legumes ______ Nuts/Seeds _______ Veg1 ________ Veg 2 _______ Fruits ______

Whole Grains ______ Oils ______ Protein _______ Medical Food _______ (Name: __________________)

How many days of the week are you able to choose ONLY foods from these food groups? _______________

I eat the recommended serving size for each food ___________ % of the time.

I eat in 3 hour intervals _____________ % of the time.

I drink ______________ ounces of water daily.

I also drink (# of servings /day): Coffee _____ Tea _____ Wine _____ Liquor _____ Beer _____ Soft Drinks _____

I eat sugar (candy, desserts, sweets): _______ times per week.

I drive, sit in front of computer and/or watch TV: _________ hours per day.

Exercise	Aerobic	Resistance (strength)	Stretching
Type			
How Long?			
#/week			

Stress Management

I can relax for 20 minutes daily ______ times per week with ____

I can get a restful night's sleep ______ times per week

Supplements

I take the following supplements daily: ____ _____ times / week

My Questions for today's appointment: ____

____

Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
   - ❑ Yes (1pt.) If yes, how many are you currently taking? _____ (1pt. each)
   - ❑ No (0pt.)

2. Are you presently taking one or more of the following over-the-counter drugs?
   - ❑ Cimetidine (2pts.)
   - ❑ Acetaminophen (2pts.)
   - ❑ Estradiol (2pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them?
   - ❑ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3pts.)
   - ❑ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2pts.)
   - ❑ Experience no side effects, drug(s) is (are) usually NOT efficacious (2pts.)
   - ❑ Experience *no* side effects, drug(s) is (are) usually efficacious (0pts.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products? ❑ Yes (2pts.) ❑ No (0pts.)

5. Do you have strong negative reactions to caffeine or caffeine containing products? ❑ Yes (1pt.) ❑ No (0pt.) ❑ Don't Know (0pt.)

6. Do you commonly experience "brain fog", fatigue or drowsiness? ❑ Yes (1pt.) ❑ No (0pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes or strong odors? ❑ Yes (1pt.) ❑ No (0pts.) ❑ Don't Know (0pt.)

8. Do you feel ill after you consume even small amounts of alcohol? ❑ Yes (1pt.) ❑ No (0pt.) ❑ Don't Know (0pt.)

9. Do you have a personal history of:
   - ❑ Environmental and/or chemical sensitivities (5pts.)
   - ❑ Chronic fatigue syndrome (5pts.)
   - ❑ Multiple chemical sensitivity (5pts.)
   - ❑ Fibromyalgia (3pts.)
   - ❑ Parkinson's type symptoms (3pts.)
   - ❑ Alcohol or chemical dependence (2pts.)
   - ❑ Asthma (1pt.)

10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
    ❑ Yes (1pt.) ❑ No (0pts.)

11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
    ❑ Yes (1pt.) ❑ No (0pt.) ❑ Don't Know (0pts.)

GRAND TOTAL __________

Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction? ❑ Yes ❑ No
2. Have you ever been diagnosed with a condition known as hyperkalemia? ❑ Yes ❑ No
3. Are you currently on diuretics or blood pressure medication? ❑ Yes ❑ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

Overall Score Tabulation

See doctor for protocol suggestions

MSQ SCORE __________ (High > 50; moderate 15-49; Low <14)

XTT SCORE __________ (High > 10; moderate 5-9; Low <4)

URINARY pH __________

NOTE: Patients with high MSQ but XTT may be exhibiting symptoms not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical food, diet/, and/or nutraceuticals.