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 MSQ QUESTIONNAIRE

Name: Date: DOB:

**Rate each of the following symptoms based on the last week using the point scale below: Part 1: Symptoms**

* 0 Never or rarely 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

**DIGESTIVE TRACT RESPIRATORY**  **JOINTS AND MUSCLES**

Nausea, Vomiting Chest Congestion Pain or aches in joints

Diarrhea Asthma, Bronchitis Arthritis, joint swelling

Constipation Shortness of breath Stiff or limitation or movement

Bloated feeling Difficulty Breathing Pain or aches in muscles

Heart Burn **Respiratory Total:**  Feeling of weakness or tired

Intestinal, Stomach pain **Joints/ Muscle Total:**

**Digestive Total:**

**EMOTIONAL** **WEIGHT/FOOD**

Mood swings Binge Eating, Drinking Underweight

Anxiety, fear, Nervousness craving certain foods Water retention

Anger, irritability, aggression Excessive weigh

Depression Compulsive eating, food additions

**Emotional Total: Weight/ Food Total:**

**ENERGY / SLEEP EYES NOSE**

Fatigue, sluggishness Watery or itchy eyes Stuffy Nose

Apathy, Lethargy Swollen, red, or sticky eyelids Sinus problems

Hyperactivity Bags or dark circles under eyes dripping nose

Restlessness, achiness Blurred or restricted vision Sneezing attacks

Sleep Disturbances **Eyes Total:** Excessive mucus

 **Energy/ Sleep Total:**  **Nose Total:**

**SKIN**  **HEART**   **HEAD**

Acne Irregular or skipped heartbeat Headaches

Hives, rashes, dry skin, redness Rapid or pounding heartbeat Faintness

Hair loss Chest pain Lightheadedness

Flushing, hot flashes **Heart Total:** Dizziness

Excessive sweating **Head Total:**

**Skin Total:**

**MOUTH / THROAT**  **EARS**

Frequent, consistent coughing Itchy Ears

Gagging, need to clear throat Earaches, ear infections

Sore throat, hoarse, loss of voice Drainage from ear, waxy buildup

Swollen or discolored tongue, gums or lips Ringing in ears, hearing loss

Canker sores, other mouth sores **Ears Total:**

 **Mouth /Throat Total:**

**COGNITIVE**  **OTHER**

Poor Memory, recall stuttering, stammering frequent illness

Confusion, poor comprehension: Slurred Speech Frequent urination

Poor concentration: Learning Disabilities Urgent urination

Poor Physical coordination: Difficulty in making decisions Genital itch or discharge

**Cognitive Total:** **Other Total:**

 **GRAND TOTAL:**

 **PART 2: Xenobiotic Tolerability Test (XTT)**

**Are you presently using prescription drugs?** YES (1 pt.) NO (0 pt.)

If yes, how many are you currently taking? (1 pt. each)

**Are you presently taking one or more of the following over-the-counter drugs?**

 Cimetidine (2pt.) Acetaminophen (2pt.) Estradiol (2pt.)

**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) (3 pts.)

 Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)

 Experience side effects; drug(s) is (are) usually not efficacious (2 pts.)

 Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

**Do you currently (with in the last 6 months) or have you regularly used tobacco products?** YES (2pt.) NO (0 pt.)

**Do you have strong negative reactions to caffeine or caffeine-containing products?**  YES (1 pt.) NO (0 pt.)

**Do you commonly experience “brain fog,” fatigue, or drowsiness?** YES (1 pt.) NO (0pt.)

**Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?**

YES (1pt.) NO (0 pt.) Don’t know (0 pt.)

**Do you feel ill after you consume even small amounts of alcohol?** YES (1 pt.) NO (0 pt.) Don’t know (0 pt.)

**Do you have a personal history of?**

 Environmental and/or chemical sensitivities (5 pts.)

 Chronic fatigue syndrome (5pts.)

 Multiple chemical sensitivity (5 pts.)

 Fibromyalgia (3pts.)

 Parkinson’s type symptoms (3pts.)

 Alcohol or chemical dependence (2pts.)

 Asthma (1pt.)

**Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents**? YES (1pt) NO (0 pt.)

**Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?** YES (1 pt.) NO (0 pt.) Don’t know (0 pt.)

 **TOTAL:**

**For Practitioner Use Only:**

Part 1: Symptoms Grand Total (High > 50; moderate 15-49; low < 14)

Part 2: XTT Total (High >10; moderate 5-9; low <4)

**Disclaimer:** This questionnaireis for information purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.