Name _____ Date _____

MUS® - Medically Unexplained Symptoms Self-Evaluation

- Mark each answer with a cross -

Do you suffer from chronic and persistent fatigue?	Yes	No
Have you been suffering from mood disorders for long?	Yes	No
Do you suffer from persistent insomnia or awakenings from sleep?	Yes	No
Do you suffer from persistent drowsiness during the day?	Yes	No
Have you been experiencing anxiety?	Yes	No
Have you been experiencing apathy?	Yes	No
Have you been suffering from panic attacks?	Yes	No
Have you been experiencing abnormal heart beats (arrhythmia or tachycardia) at rest?	Yes	No
Have you noticed changes in your appetite (excessive hunger or loss of appetite)?	Yes	No
Do you suffer from night hunger pangs (night binge eating disorder)?	Yes	No
Have you been suffering from heartburn, stomach fullness, bloating or nausea?	Yes	No
Do you suffer from irritable bowel syndrome?	Yes	No
Have you periodically been suffering from constipation or altered bowel movement?	Yes	No
Do you usually have cold hands and feet?	Yes	No
Do you suffer from altered perspiration during sleep?	Yes	No
Do you often wake up in a bad mood?	Yes	No
Have you been experiencing feelings of unjustified guilt?	Yes	No
Do you have difficulties in experiencing pleasure or relief, as a result of positive events?	Yes	No
Have you recently experienced significant weight loss?	Yes	No

Age: _____ Gender : _____ Weight : _____Height:_____

BIOTEKNA MEDICAL

Rev: 6 - 2020