

## View results

Respondent

44

Anonymous

36:35

Time to complete

### 1. Name \*

Amy Kos

## 2. Upper GIT \*

	Frequently	Often	Someti
Indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive Burping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foods sits for long periods after a meal	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Bad breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of appetite	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Stomach pain/burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heartburn after spicy, citrus, alcohol, caffeine or fatty foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dark or Black tarry stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upper abdominal cramps or aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### 3. Lower GIT \*

	Frequently	Often	Sometin
Lower abdominal pain or cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive gas, flatulence	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Nausea and/or vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhoea, loose watery bowel movements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation, straining, hard dry stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternating constipation and diarrhoea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undigested food in stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensation of incomplete emptying of bowel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extreme narrow stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mucus or pus in stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red blood with bowel movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Black or dark colour patches in stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rectal pain or cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 4. Liver, Gall Bladder, Pancreas \*

	Frequently	Often	Someti
Abdominal pain or pain under ribs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatty foods cause indigestion or nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unexplained itchy skin	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Yellow cast to skin, eyes or dark coloured urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clay coloured stools	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Malaise or weakness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Fluid retention, oedema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Easy bruising or bleeding e.g gums	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red skin, particularly palms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dry skin and or hair	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

## 5. Endocrine - Thyroid \*

	Frequently	Often	Someti
Fatigue, sluggishness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Feel cold or intolerance to cold	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Feeling hot, intolerance to heat, sweaty	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Puffy face, hands or feet	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Unintentional weight gain or weight loss	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swelling or tightness in front of neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low mood	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Low libido	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Heavier or more frequent menstrual periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Light infrequent or absent menstrual periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue or notable weakness in limbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness, irritability, restlessness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Visual disturbance or development of a staring gaze	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

## 6. Endocrine - Adrenals \*

	Frequently	Often	Someti
Feeling stressed, nervous, tense, unable to relax	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Feeling oversensitive and overwhelmed, unable to cope	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Low mood, mood swings	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Difficulty concentrating or thinking straight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Need stimulants like coffee, tea, sugar, tobacco as pick me ups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel fatigued after stressful day or event	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Find it hard to get up and going in morning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty staying awake during the day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea or dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations and/or chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**7. Endocrine - Female Hormones *Experience 3-14 days prior to period* \***

	Frequently	Often	Someti
Abdominal bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast tenderness, swelling or lumps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling depressed, anxious, teary or sensitive or easily angered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhoea or constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache or migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food cravings or binge eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fluid retention or weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clumsiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling aggressive or suicidal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 8. Endocrine - Female Reproductive ***Experienced in last 6 months during menstruation \****

	Frequently	Often	Sometimes
Irregular intervals between periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal bleeding between periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pelvic or rectal pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea and/or vomiting with menses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Light blood flow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heavy blood flow or flooding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Larger blood clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prolonged duration of bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Absence of menses for longer than 3 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## 9. Endocrine - Female Reproductive \*

	Frequently	Often	Someti
Cycle becoming erratic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menses becoming heavier or lighter in flow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dry skin, hair and/or vagina	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Low libido	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Hot flushes, Night sweats	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Painful intercourse	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Increased facial hair eg. upper lip	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Milk production (not nursing)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive Libido	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Miscarriage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infertility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal discharge, smelly or coloured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning or itching of external genitalia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal bleeding after intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast lumps or change in breast size or shape	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Change in nipple appearance and/or discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 10. Glucose Tolerance \*

	Frequently	Often	Someti
Skipping meals causes fatigue, weakness or headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skipping meals causes sweating, palpitations, light headedness or faint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult concentration if miss meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel agitated, irritable if miss meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive frequent urination	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased thirst and appetite	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurred Vision, failing eyesight	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue, drowsiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Profuse sweating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness when stand from seated position	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
unintentional weight loss or weight gain	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Diagnosis of diabetes or pre diabetic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 11. Allergy, Immune \*

Frequently Often Someti

Frequent colds and flus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent infections in other areas e.g. ears, skin, bladder	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Nasal congestion or discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of inflamed throat, or tonsillitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Scratchy throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Persistent or frequent cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cold sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wounds heal slowly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive loss of hair	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swollen glands in neck, armpit, groin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine or headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitivity to light	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Localised general itching - eyes, ears, throat, nose, skin	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Sneezing, coughing or wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Certain foods worsen symptoms or cause heart palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 12. Respiratory \*

	Frequently	Often	Someti
Increased effort to breathe, wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough dry or moist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thick yellow, greenish or brown or blood stained sputum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frothy sputum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Noisy rattling sounds when breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 13. Urinary \*

	Frequently	Often	Someti
Frequent fluid retention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower back pain	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Excessive, frequent urination, waking through night	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Buring with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urgency of urination	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Bloody, cloudy or darkened or strong smelling urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incontinence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infrequent urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severe one sided lower back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 14. Haematological - Anaemia \*

	Frequently	Often	Someti
Prolonged recovery after exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low exercise tolerance, shortness of breath with exertion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult to think straight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pale eyelids, lips, gums, nails	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red sore tongue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sores in corner of mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Easy bruising or bleeding	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Restless legs at night	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

## 15. Cardiovascular, Circulation \*

	Frequently	Often	Someti
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nosebleeds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Redness in face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ringing in ears or blurred vision	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
History of high blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Pain or heaviness in central chest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pallor or sweating with chest discomfort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shortness of breath lying flat or on sudden waking in middle of night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheezing or dry cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swelling in feet, ankles or legs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
History of high blood cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cold extremities, numbness, tingling or pricking sensations in hands or feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White or blueish tinge to lips, fingers or toes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Faints or falls for unknown reason	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Brief loss of vision, co-ordination difficult speaking, swallowing or understanding speech or written word	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 16. Musculoskeletal, Connective Tissue \*

	Frequently	Often	Someti
Bone tenderness, pain or achiness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Lower back or hip pain	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Walking difficulties or a limp	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosis of Osteoporosis or unexplained bone fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spinal curvature, Stooped posture or hump at base of neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle tightness, tension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specific body points tender to touch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle cramps or spasms	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Muscle twitch or tremble	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle loss and wasting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tender red, swollen, stiff joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dry mouth, dry painful eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creaking noisy joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Joint pain involving multiple joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limited range of motion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty standing from seated position	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty chewing or opening mouth	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>



## 17. Neurological, Brain, Sleep \*

	Frequently	Often	Someti
Lightheadedness, fainting	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Ringing or buzzing in ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trembling hands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Numbness, pins and needles or tingling in limbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unsteady on feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor hand co-ordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Convulsions, seizures or funny turns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drooping eyelids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impaired hearing, eyesight, sense of touch, smell or taste	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Slow or slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Find it difficult to keep still or fidgety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a short attention span	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Experience mental confusion or sluggishness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have or had learning difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 18. Skin \*

	Frequently	Often	Sometimes
Eczema, Dermatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psoriasis	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Dandruff, Tinea or fungal infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pigmentation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin rashes	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>