

View results

Respondent

14

Anonymous

316:55

Time to complete

1. Name *

Alan Wilson

2. Upper GIT *

	Frequently	Often	Sometimes	Never
Indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Excessive Burping	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Foods sits for long periods after a meal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Bad breath	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Loss of appetite	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Stomach pain/burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Heartburn after spicy, citrus, alcohol, caffeine or fatty foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Dark or Black tarry stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Upper abdominal cramps or aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

3. Lower GIT *

	Frequently	Often	Sometimes	Never
Lower abdominal pain or cramps	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Excessive gas, flatulence	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Nausea and/or vomiting	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Diarrhoea, loose watery bowel movements	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Constipation, straining, hard dry stools	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alternating constipation and diarrhoea	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Undigested food in stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Sensation of incomplete emptying of bowel	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Extreme narrow stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Mucus or pus in stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Red blood with bowel movement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Black or dark colour patches in stool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Rectal pain or cramps	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Anal itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

4. Liver, Gall Bladder, Pancreas *

	Frequently	Often	Sometimes	Never
Abdominal pain or pain under ribs	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Fatty foods cause indigestion or nausea	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Unexplained itchy skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Yellow cast to skin, eyes or dark coloured urine	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Clay coloured stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Malaise or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fluid retention, oedema	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Easy bruising or bleeding e.g gums	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Red skin, particularly palms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Dry skin and or hair	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Endocrine - Thyroid *

	Frequently	Often	Sometimes	Never
Fatigue, sluggishness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel cold or intolerance to cold	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Feeling hot, intolerance to heat, sweaty	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Puffy face, hands or feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Unintentional
weight gain
or weight loss

☐☐☐☒

Swelling or
tightness in
front of neck

☐☐☐☒

Low mood

☐☐☒☐

Low libido

☐☐☒☐

Fatigue or
notable
weakness in
limbs

☐☐☒☐

Nervousness,
irritability,
restlessness

☐☐☒☐

Visual
disturbance
or
development
of a staring
gaze

☐☐☐☒

6. Endocrine - Adrenals *

Frequently

Often

Sometimes

Never

Feeling
stressed,
nervous,
tense, unable
to relax

☐☐☒☐

Feeling
oversensitive
and
overwhelmed
, unable to
cope

☐☐☒☐

Low mood,
mood swings

☐☐☒☐

Difficulty
concentrating
or thinking
straight

☐☐☒☐

Need
stimulants
like coffee,
tea, sugar,
tobacco as
pick me ups

☐☒☐☐

Feel fatigued
after stressful
day or event

☐☒☐☐

Find it hard
to get up and
going in
morning

☐☐☒☐

Difficulty
staying
awake during
the day

☐☒☐☐

Nausea or
dizziness

☐☐☐☒

Palpitations
and/or chest
pain

☐☐☐☒

7. Endocrine - Male Reproductive *

Frequently

Often

Sometimes

Never

Difficulty
starting or
poor urine
flow

☐☐☐☒

Sense of
bladder
fullness,
incomplete
emptying, or
strain with
small
amounts of
urine passed

☐☐☐☒

Dripping
after
urination

☐☐☐☒

Ejaculation
causes pain

☐☐☐☒

Blood in
semen

☐☐☐☒

Low Libido

☐☐☒☐

Difficulty attaining or maintaining an erection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Premature ejaculation	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Low energy, stamina	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Development of breasts or nipple tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Infertility, low sperm count or poor sperm mobility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Testicles uneven in size, texture or hardness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Inflammation of penis or unusual discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Genital or groin rash, itchiness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Painful testicles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Loss, thinning
or slow
growing
body or facial
hair

☐☐☒☐

8. Glucose Tolerance *

Frequently

Often

Sometimes

Never

Skipping
meals causes
fatigue,
weakness or
headaches

☐☐☒☐

Skipping
meals causes
sweating,
palpitations,
light
headedness
or faint

☐☐☐☒

Difficult
concentration
if miss meals

☐☐☐☒

Feel agitated,
irritable if
miss meals

☐☐☒☐

Excessive
frequent
urination

☐☐☒☐

Increased
thirst and
appetite

☐☐☒☐

Blurred Vision, failing eyesight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Fatigue, drowsiness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Profuse sweating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Dizziness when stand from seated position	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
unintentional weight loss or weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Diagnosis of diabetes or pre diabetic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

9. Allergy, Immune *

	Frequently	Often	Sometimes	Never
Frequent colds and flus	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Frequent infections in other areas e.g. ears, skin, bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Nasal congestion or discharge	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
History of inflamed throat, or tonsillitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Scratchy throat	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Persistent or frequent cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Cold sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Mouth Ulcers	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Wounds heal slowly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Excessive loss of hair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Swollen glands in neck, armpit, groin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Migraine or headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Sensitivity to light	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Localised
general
itching - eyes,
ears, throat,
nose, skin

☐☐☒☐

Sneezing,
coughing or
wheezing

☐☐☒☐

Certain foods
worsen
symptoms or
cause heart
palpitations

☐☐☐☒

10. Respiratory *

	Frequently	Often	Sometimes	Never
Increased effort to breathe, wheezing	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Cough dry or moist	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Thick yellow, greenish or brown or blood stained sputum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Frothy sputum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Noisy rattling sounds when breathing	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

11. Urinary *

	Frequently	Often	Sometimes	Never
Frequent fluid retention	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Lower back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Excessive,
frequent
urination,
waking
through night

☐☒☐☐

Burning with
urination

☐☐☐☒

Urgency of
urination

☐☒☐☐

Bloody,
cloudy or
darkened or
strong
smelling
urine

☐☐☒☐

Incontinence

☐☐☒☐

Infrequent
urination

☐☐☐☒

Severe one
sided lower
back pain

☐☐☐☒

History of
kidney
stones

☐☐☐☒

12. Haematological - Anaemia *

	Frequently	Often	Sometimes	Never
Prolonged recovery after exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Low exercise tolerance, shortness of breath with exertion	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficult to think straight	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Pale eyelids, lips, gums, nails	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Red sore tongue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Sores in corner of mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Easy bruising or bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Restless legs at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

13. Cardiovascular, Circulation *

Frequently	Often	Sometimes	Never
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Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Nosebleeds	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Redness in face	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Ringing in ears or blurred vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
History of high blood pressure	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Pain or heaviness in central chest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Pallor or sweating with chest discomfort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Shortness of breath lying flat or on sudden waking in middle of night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Wheezing or dry cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Swelling in
feet, ankles
or legs

☐☐☐☒

History of
high blood
cholesterol

☐☐☐☒

Cold
extremities,
numbness,
tingling or
pricking
sensations in
hands or feet

☐☒☐☐

White or
blueish tinge
to lips,
fingers or
toes

☐☐☒☐

Faints or falls
for unknown
reason

☐☐☐☒

Brief loss of
vision, co-
ordination
difficult
speaking,
swallowing or
understandin
g speech or
written word

☐☐☐☒

14. Musculoskeletal, Connective Tissue *

Frequently

Often

Sometimes

Never

Bone tenderness, pain or achiness	<input type="radio"/>	<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"/>	<input type="radio"/>
Walking difficulties or a limp	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosis of Osteoporosis or unexplained bone fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Spinal curvature, Sto oped posture or hump at base of neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Muscle tightness, tension	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Specific body points tender to touch	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Muscle cramps or spasms	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Muscle twitch or tremble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Muscle loss and wasting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Tender red, swollen, stiff joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Dry mouth, dry painful eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Creaking noisy joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Joint pain involving multiple joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Limited range of motion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Difficulty standing from seated position	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Difficulty chewing or opening mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

15. Neurological, Brain, Sleep *

Frequently

Often

Sometimes

Never

Lightheadedness, fainting

☐☐☐☒

Ringing or buzzing in ears

☐☐☒☐

Trembling hands

☐☒☐☐

Numbness, pins and needles or tingling in limbs

☐☐☒☐

Unsteady on feet

☐☒☐☐

Poor hand co-ordination

☐☒☐☐

Convulsions, seizures or funny turns

☐☐☐☒

Drooping eyelids

☐☐☒☐

Impaired hearing, eyesight, sense of touch, smell or taste

☐☐☐☒

Slow or slurred speech

☐☐☒☐

Difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Difficulty staying asleep	<input type="radio"/>	<input checked="" 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"/>	<input checked="" type="radio"/>
Have a short attention span	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Experience mental confusion or sluggishness	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Have or had learning difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

16. Skin *

	Frequently	Often	Sometimes	Never
Eczema, Dermatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Psoriasis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Dandruff, Tinea or fungal infections	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Pigmentation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Skin rashes	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>