

View results

Respondent

66

Anonymous

24:10

Time to complete

1. Name *

Amanda Whitford

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Long periods
after a meal

Bad breath

Loss of
appetite

Stomach
pain/burning

Heartburn after
spicy, citrus,
alcohol, caffeine
or fatty foods

Dark or Black
tarry stools

Upper
abdominal
cramps or
aches

3. Lower GIT *

Frequently

Often

Sometimes

Never

Lower
abdominal pain
or cramps

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 checked="" type="radio"/>	<input 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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undigested food in stools	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensation of incomplete emptying of bowel	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extreme narrow stools	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input 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

Black or dark
colour patches
in stool

Rectal pain or
cramps

Anal itching

4. Liver, Gall Bladder, Pancreas *

Frequently

Often

Sometimes

Never

Abdominal pain
or pain under
ribs

Fatty foods
cause
indigestion or
nausea

Unexplained
itchy skin

Yellow cast to
skin, eyes or
dark coloured
urine

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 type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

5. Endocrine - Thyroid *

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

Puffy face, hands or feet	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Unintentional weight gain or weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swelling or tightness in front of neck	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Low mood	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low libido	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Heavier or more frequent menstrual periods	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Light infrequent or absent menstrual periods	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Fatigue or notable weakness in limbs	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nervousness, irritability, restlessness	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 - Female Hormones ***Experience 3-14 days prior to period ****

Frequently

Often

Sometimes

Never

Abdominal bloating

Breast tenderness, swelling or lumps

Feeling depressed, anxious, teary or sensitive or easily angered	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhoea or constipation	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache or migraines	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food cravings or binge eating	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fluid retention or weight gain	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Clumsiness	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling aggressive or suicidal	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Freuenty	Often	Sometimes	Never
Irregular intervals between periods	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Vaginal bleeding between periods	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Painful periods	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Pelvic or rectal pressure	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Nausea and/or vomiting with menses	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Light blood flow	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Heavy blood flow or flooding	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Larger blood clots	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prolonged duration of bleeding	<input checked="" type="radio"/>	<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"/>	<input checked="" type="radio"/>

9. Endocrine - Female Reproductive *

	Frequently	Often	Sometimes	Never
Cycle becoming erratic	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menses becoming heavier or lighter in flow	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Dry skin, hair and/or vagina	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low libido	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Hot flushes, Night sweats	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Increased facial hair eg. upper lip	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Milk production (not nursing)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Excessive Libido	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Miscarriage	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Infertility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Vaginal discharge, smelly or coloured

Burning or itching of external genitalia

Vaginal bleeding after intercourse

Breast lumps or change in breast size or shape

Change in nipple appearance and/or discharge

10. 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

Fatigue, drowsiness

Profuse sweating

Dizziness when stand from seated position

unintentional weight loss or weight gain

Diagnosis of diabetes or pre diabetic

11. Allergy, Immune *

Frequently

Often

Sometimes

Never

Frequent colds and flus

Frequent infections in other areas e.g. ears, skin, bladder

Nasal congestion or discharge

History of inflamed throat, or tonsillitis

Scratchy throat

Persistent or frequent cough

Cold sores

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" 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 checked="" type="radio"/>	<input type="radio"/>
Swollen glands in neck, armpit, groin	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Migraine or headaches	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitivity to light	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Localised general itching - eyes, ears, throat, nose, skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Sneezing, coughing or wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Certain foods worsen symptoms or cause heart palpitations	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

12. Respiratory *

	Frequently	Often	Sometimes	Never
Increased effort to breathe, wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Cough dry or moist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" 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 type="radio"/>	<input checked="" type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

13. 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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive, frequent urination, waking through night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Buring with urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Urgency of urination	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Bloody, cloudy or darkened or strong smelling urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Incontinence	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Infrequent urination	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Severe one sided lower back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

History of kidney stones

14. Haematological - Anaemia *

Frequently

Often

Sometimes

Never

Prolonged recovery after exercise

Low exercise tolerance, shortness of breath with exertion

Difficult to think straight

Pale eyelids, lips, gums, nails

Red sore tongue

Sores in corner of mouth

Easy bruising or bleeding

Restless legs at night

15. Cardiovascular, Circulation *

	Frequently	Often	Sometimes	Never
Headaches	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nosebleeds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Redness in face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
ringing in ears or blurred vision	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input 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 checked="" type="radio"/>	<input 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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pallor or sweating with chest discomfort	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Shortness of

breath lying flat
or on sudden
waking in
middle of night

Wheezing or
dry cough

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 understanding speech or written word

16. Musculoskeletal, Connective Tissue *

Frequently Often Sometimes Never

Bone tenderness, pain or achiness

Lower back or hip pain

Walking difficulties or a limp

Diagnosis of Osteoporosis or unexplained bone fracture

Spinal curvature, Stoo

- - - -

poor posture or hump at base of neck

Muscle tightness, tension

Specific body points tender to touch

Muscle cramps or spasms

Muscle twitch or tremble

Muscle weakness

Muscle loss and wasting

Tender red, swollen, stiff joints

Dry mouth, dry painful eyes

Creaking noisy joints

Joint pain

Joint pain involving multiple joints	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Limited range of motion	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input 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"/>

17. Neurological, Brain, Sleep *

	Frequently	Often	Sometimes	Never
Lightheadedness, fainting	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Ringing or buzzing in ears	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Trembling hands	<input checked="" type="radio"/>	<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"/>	<input checked="" type="radio"/>
Unsteady on feet	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Poor hand co-ordination	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Convulsions, seizures or funny turns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Drooping eyelids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Impaired hearing, eyesight, sense of touch, smell or taste	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Slow or slurred speech	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Difficulty falling asleep	<input checked="" type="radio"/>	<input type="radio"/>	<input 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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a short attention span	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Experience
mental
confusion or
sluggishness

Have or had
learning
difficulties

18. Skin *

Frequently

Often

Sometimes

Never

Eczema,
Dermatitis

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