

Please review the list of symptoms below.

Check "yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months check "No" box if you do not.

GENERAL		SKIN		MUSCULAR SKELETAL	
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hiccups	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	GASTROINTESTINAL		Locking Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lethargy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Malaise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red or Swollen in Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Masses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	HEMATOLOGY/ONCOLOGY	
Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia or Low Blood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Bruise	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Burn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Lymph Nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancers	<input type="checkbox"/> Yes <input type="checkbox"/> No
EYES		Black Tarry Stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHIATRIC	
Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression or Sadness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feel like hurting someone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oculodysnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	GENITOURINARY		Feel like hurting yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No
Photophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems Urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernias	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urination at Night	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Sexual Transmitted Dz.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY			
Leg Pain with Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with period	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Problems with Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Swelling in Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with Sex	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Problems Lying Flat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Skipping Heart Beats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Short of breath at night	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lumps in Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No		
RESPIRATORY		Breast Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	MEN ONLY			
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with Erections	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Coughing up Blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dribbling of Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weak Urine Stream	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Testicles	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No					