

Please check off any of the following symptoms that you have ever had. Use the following marks:

+ I have this symptom often.

✓ I have this symptom sometimes.

Place parentheses () around + or ✓ if it was in the past, and no longer an issue.

<input type="checkbox"/> lack of appetite	<input type="checkbox"/> intolerance to weather changes	<input type="checkbox"/> sciatic pain
<input type="checkbox"/> loose stools/diarrhea	<input type="checkbox"/> allergies/hay fever	<input type="checkbox"/> dislike of cold
<input type="checkbox"/> bloating/distension in the stomach	<input type="checkbox"/> asthma	<input type="checkbox"/> cold hands & feet
<input type="checkbox"/> flatulence	<input type="checkbox"/> swollen face	<input type="checkbox"/> whole body cold
<input type="checkbox"/> colitis or diverticulitis	<input type="checkbox"/> pain under the rib cage	<input type="checkbox"/> whole body hot
<input type="checkbox"/> constipation	<input type="checkbox"/> frequent sighing	<input type="checkbox"/> dark yellow urine
<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> frequent hiccups	<input type="checkbox"/> bitter taste in mouth
<input type="checkbox"/> fatigue	<input type="checkbox"/> moodiness	<input type="checkbox"/> dry throat/mouth
<input type="checkbox"/> sweet taste in mouth	<input type="checkbox"/> tendency to anger easily	<input type="checkbox"/> thirst & desire to drink
<input type="checkbox"/> tendency to become obsessive (in relationships, etc)	<input type="checkbox"/> irritability	<input type="checkbox"/> blood in stool
<input type="checkbox"/> easily bruised	<input type="checkbox"/> excessive sex drive	<input type="checkbox"/> vomiting blood
<input type="checkbox"/> difficult to stop bleeding	<input type="checkbox"/> alternating loose stools & constipation	<input type="checkbox"/> burning sensation in anus
<input type="checkbox"/> indigestion	<input type="checkbox"/> feeling of a lump in the throat	<input type="checkbox"/> nosebleeds
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> pain/coldness in genital area	<input type="checkbox"/> fever
<input type="checkbox"/> burping/belching	<input type="checkbox"/> blurred vision	<input type="checkbox"/> convulsions
<input type="checkbox"/> vomiting	<input type="checkbox"/> "floaters" in the eyes	<input type="checkbox"/> sweating at night
<input type="checkbox"/> stomach pains	<input type="checkbox"/> muscle twitching/spasm	<input type="checkbox"/> feeling of heat in the afternoon
<input type="checkbox"/> noisy stomach	<input type="checkbox"/> numbness/tingling of limbs	<input type="checkbox"/> palms, feet, & chest hot
<input type="checkbox"/> constant hunger	<input type="checkbox"/> paralysis	<input type="checkbox"/> flushed cheeks
<input type="checkbox"/> bleeding or swollen painful gums	<input type="checkbox"/> dry skin	<input type="checkbox"/> uneasiness/fidgetiness
<input type="checkbox"/> bad breath	<input type="checkbox"/> brittle nails	<input type="checkbox"/> dry mouth/throat at night
<input type="checkbox"/> insomnia/difficulty sleeping	<input type="checkbox"/> pale lips	<input type="checkbox"/> thirst w/no desire to drink
<input type="checkbox"/> palpitations	<input type="checkbox"/> difficulty digesting fats	<input type="checkbox"/> head feels "muzzy"
<input type="checkbox"/> dream-disturbed sleep/nightmares	<input type="checkbox"/> lack of courage	<input type="checkbox"/> feeling of heavy limbs
<input type="checkbox"/> anxiety/mental restlessness	<input type="checkbox"/> lack of initiative	<input type="checkbox"/> body aches
<input type="checkbox"/> laughing for no reason	<input type="checkbox"/> difficulty making decisions	<input type="checkbox"/> lack of taste
<input type="checkbox"/> chest pain/angina	<input type="checkbox"/> timidity	<input type="checkbox"/> feeling full after eating
<input type="checkbox"/> mouth or tongue sores	<input type="checkbox"/> gallstones	<input type="checkbox"/> phlegm in throat
<input type="checkbox"/> pain radiating to left arm or shoulder	<input type="checkbox"/> jaundice	<input type="checkbox"/> sudden weight loss
<input type="checkbox"/> spontaneous sweating	<input type="checkbox"/> light-colored stool	
<input type="checkbox"/> shortness of breath (SOB) on exertion	<input type="checkbox"/> low back pain	
<input type="checkbox"/> SOB upon resting	<input type="checkbox"/> knee pain	
<input type="checkbox"/> propensity for catching colds	<input type="checkbox"/> weak legs	
<input type="checkbox"/> cough	<input type="checkbox"/> hearing impairment	
<input type="checkbox"/> weak voice	<input type="checkbox"/> ear ringing/tinnitus	
<input type="checkbox"/> dislike of speaking	<input type="checkbox"/> kidney stones	
<input type="checkbox"/> hoarse voice	<input type="checkbox"/> low/decreased sex drive	
<input type="checkbox"/> stuffy nose	<input type="checkbox"/> hair loss	
<input type="checkbox"/> runny nose	<input type="checkbox"/> frequent urination	
<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> frequent urination at night	
<input type="checkbox"/> skin problems	<input type="checkbox"/> painful urination	
<input type="checkbox"/> bronchitis	<input type="checkbox"/> difficulty urinating	
	<input type="checkbox"/> incontinence	
	<input type="checkbox"/> difficulty inhaling	
	<input type="checkbox"/> edema of the legs	
	<input type="checkbox"/> tendency toward fear	

WOMEN:

<input type="checkbox"/> PMS
<input type="checkbox"/> breast distension
<input type="checkbox"/> vaginal discharge
<input type="checkbox"/> vaginal itching
<input type="checkbox"/> lack of period
<input type="checkbox"/> infertility

MEN:

<input type="checkbox"/> pain/swelling of scrotum
<input type="checkbox"/> impotence
<input type="checkbox"/> premature ejaculation
<input type="checkbox"/> BPH