

Weird Symptom Questionnaire

Some conditions can have weird symptoms. Please answer whether you have had these:

general:

- | | | | | |
|--|--|---|---------------------------------------|-----------------------------|
| fevers | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| weight loss (without trying) | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| severe night sweats (soaking sheets and pillow) | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| severe fatigue | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| feel cold all the time (when others feel normal) | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| feel hot all the time (when others feel normal) | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| difficulty controlling bladder | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| swollen glands (in neck, armpits, groins) | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| swollen glands get worse after drinking alcohol | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| dizzy when you stand up out of bed | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| difficulty concentrating/focusing | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |

digestive:

- | | | | | |
|--|--|---|---------------------------------------|-----------------------------|
| belly pain | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| diarrhea (liquid stool) | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| bloody, or black/tarry stools | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| excessive urination - seems like gallons | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| urine is foamy - like it has soap in it | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| urine is dark - red or brown | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |

chest:

- | | | | | |
|---|--|---|---------------------------------------|-----------------------------|
| shortness of breath | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| chest pain when you take a deep breath | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| coughing up blood and clots | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| chest pain when you exercise/climb stairs | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| asthma that started suddenly after age 40 | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |

joints/muscles/bones:

- | | | | | |
|---|--|---|---------------------------------------|-----------------------------|
| joint pains | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| joints swelling up | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| one joint exquisitely painful, red and hot | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| morning joint stiffness , for more than 1 hour | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| muscle pain without joint pain | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| muscles are weak, can't make them work | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| muscles are visibly twitching and trembling | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| spinal pain | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| numbness or tingling | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| hand or voice tremor | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| hard bony lumps under the skin - painless | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| soft, dark, painful lumps on the legs | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| fingers/ toes going numb <i>and</i> turning white or blue | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| feet burn/ sting at night | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |
| swelling of hands, feet, legs, and/or face | <input type="checkbox"/> yes, recently | <input type="checkbox"/> yes, for a long time | <input type="checkbox"/> not recently | <input type="checkbox"/> no |

head/neck:

headaches	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
red eyes	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
dry eyes	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
double vision	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
vision going gray	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
mouth sores	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
dry mouth	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
mouth swelling	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
enlarged tongue	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
difficulty swallowing (food sticks)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
pain with swallowing	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
change in voice (soft, high-pitched, hoarse, etc.)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
pain in jaw and/or ear/s	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
cramping pain in jaw muscles while chewing	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
swelling along sides of face, in front of ears	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no

hair/skin/nails:

hair loss	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
psoriasis	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
skin/ eyes turning yellow	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
tight skin	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
change in size of hands	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
sausage fingers (swollen, enlarged fingers)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
pitted fingernails	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
skin is dark red around the nails, or across the knuckles	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
pain or burning in the fingertips (not the joints)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
sores in mouth or nose	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
severely increased sweating	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
skin rash or patches of unusual skin	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
worsening of rashes or fatigue after being in sunshine	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
purplish lacy pattern on skin, especially when cold	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no

blood problems/ abnormal lab tests:

bleeding/ bruising tendency	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
blood clot in leg or lung	<input type="checkbox"/> yes, more than once	<input type="checkbox"/> yes, once	<input type="checkbox"/> no	
anemia (low red blood cells found on blood test)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
abnormal white blood count (found on blood test)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
low platelets (found on blood test)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
blood in pee (found on urine test)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
protein in pee (found on urine test)	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no

women:

vaginal dryness	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
vaginal sores	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
miscarriages	<input type="checkbox"/> yes, more than two	<input type="checkbox"/> yes, once or twice	<input type="checkbox"/> no	
premature births	<input type="checkbox"/> yes, more than two	<input type="checkbox"/> yes, once or twice	<input type="checkbox"/> no	
nipple discharge	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no
facial <i>and</i> chest hair	<input type="checkbox"/> yes, recently	<input type="checkbox"/> yes, for a long time	<input type="checkbox"/> not recently	<input type="checkbox"/> no