

Please indicate how much you have been bothered by the following problems in the past 7 days:

SKIN	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	SHARE WITH YOUR
Abnormal skin colour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	Dermatologist, GP
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Thickened skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Sores on skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
EYES	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	SHARE WITH YOUR
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	Ophthalmologist, GP
Need to use eye drops frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Difficulty seeing clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
MOUTH	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	SHARE WITH YOUR
Need to avoid certain foods due to mouth pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	Dermatologist, GP
Ulcers in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
LUNGS	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	SHARE WITH YOUR
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	Respirologist, GP
Coloured sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
NUTRITION	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	SHARE WITH YOUR
Difficulty swallowing solid foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	Gastroenterologist, GP
Difficulty swallowing liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
ENERGY	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	SHARE WITH YOUR
Shortness of breath with exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	GP
Joint and muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Limited joint movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Weak muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Need to sleep more/take naps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
PSYCHOLOGICAL	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY	PREVIOUS APPOINTMENT	NEXT APPOINTMENT	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	GP
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/ /	/ /	