Wilson's Syndrome checklist

Name_____ Date_____

Please fill in the box in the appropriate column with a number value. Column #1 corresponds to the severity of your condition *before* treatment. The 2nd column corresponds to how you are after ending the 1st cycle. If you needed more than one cycle to stabilize 98.6 temp., use the third 3rd column after the completion of the total therapy. A '0' value can be left as a blank box. ☺ 0 ⟶ 4 ☹

1	2	3	
			Fatigue
			Headaches/Migraines
			Irritable bowel syndrome
			Constipation
			Weight: can't lose it
			Weight: can't gain
			Decreased memory
			Decreased concentration
			Depression
			Anxiety
			Irritability
			Panic attacks
			Fluid retention
			Low sex drive
			PMS
			Menstrual disorders
			Infertility
			After delivery health changes
			Low motivation/ambition
			Dry skin
			Dry hair
			Acne
			Brittle nails
			Unhealthy nails
			Blood pres. *too low*
			Blood pres. Too high

1	2	3	
			Cholesterol too high
			Allergies
			Hives
			Asthma
			Itchiness
			Dry eyes
			Hair loss
			Blurred vision
			Ringing in the ears
			Abnormal swallowing sensations
			Muscle and Joint aches
			Fibromyalgia
			Carpal Tunnel syndrome
			Slow healing
			Easy bruising
			Cold hands/feet
			Raynaud's phenomenon
			Cold intolerance
			Heat intolerance
			Flushing
			Sweating abnormalities
			Immune weakness
			Chronic recurrent infections
			Insomnia
			Narcolepsy
			Other_____

Please fill out the questionnaire before your office visit.