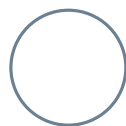




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< SURVEY LIST



SURVEY TITLE

Your Medications (Controls)

---



Are you currently taking medications (prescription or over the counter) for any of the following conditions?

HINT TEXT

(EMPTY)

MULTI SELECT (PNTA ENABLED)

OPTIONS: PAIN

CONSTIPATION

BOWEL INCONTINENCE

URINARY DYSFUNCTION

SEXUAL DYSFUNCTION

DEPRESSION

ANXIETY

SLEEP PROBLEMS

PROBLEMS WITH COGNITION (E.G. TROUBLE THINKING OR STAYING FOCUSED) OR MEMORY

PSYCHOSES (E.G. SEEING OR HEARING THINGS THAT YOU KNOW OR ARE TOLD ARE NOT THERE)

I AM NOT TAKING MEDICATION TO TREAT ANY OF THE CONDITIONS LISTED ABOVE

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Are you currently taking any of the following supplements or vitamins? Please select all that apply.

HINT TEXT

(EMPTY)

MULTI SELECT (PNTA ENABLED)

OPTIONS: COQ10

CREATINE

VITAMIN C (ALONE OR IN A MULTIVITAMIN)

VITAMIN D (ALONE OR IN A MULTIVITAMIN)

VITAMIN E (ALONE OR IN A MULTIVITAMIN)

I AM NOT TAKING ANY OF THE SUPPLEMENTS OR  
VITAMINS ABOVE

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