1) Do you experience visual disturbances (sensitivity to light, blurring, eye pain)?

	Response (%)	Responses
Yes	74.19	69
No	25.81	24
Answered Question		93
Skipped Question		1

2) Do you experience Irritable Bowel?

	Response (%)	Responses
Yes	63.04	58
No	36.96	34
Answered Question		92
Skipped Question		2

3) Do you experience Chills and night sweats?

	Response (%)	Responses
Yes	67.74	63
No	32.26	30
Answered Question		93
Skipped Question		1