Carnicom Institute MRP Symptom Survey [short version]

Carnicom Institute Morgellons Research Project Symptom Survey

Your unique Response ID is: {SAVEDID}

Please record this number to reference this survey.

INTRODUCTION: MORGELLONS RESEARCH PROJECT

This phase of the Morgellons Research Project is restricted to data collection through this survey only.

Welcome to the Morgellons Research Project Survey administered by Carnicom Institute. This is the first phase of a research project dedicated to understanding the phenomenon commonly referred to as the “Morgellons" condition. The first phase consists of an online comprehensive questionnaire and survey that we invite you to contribute towards. This current survey is subject to future revisions and refinements. Subsequent developments of data collection and/or clinical studies may develop in the future depending upon support and resources.

This study will be conducted in an anonymous and confidential manner for research purposes only. There will be no medical diagnosis or individual interpretation(s) given. The research project is intended for scientific purposes and the knowledge obtained will be for the public benefit.

You will be able to save your results and return to the survey at a later time if you like.

All responses are voluntary.

To get started, click the “Next” button below. We appreciate your interest in this project.

Disclaimer: The Carnicom Institute is a not for profit educational and research organization. It serves the public welfare. We do not advocate any particular products, protocols, or therapies related to health or environmental safeguards. Carnicom Institute has no responsibility to respond to individual requests for information or assistance. Any information provided through this survey does not obligate Carnicom Institute to act in any way.

There are 151 questions in this survey

Consent, Privacy, FAQ's

[]

Consent Agreement

I agree to allow the Carnicom Institute to save my responses and use this information as part of a research study. This survey is anonymous. Any information collected will be kept confidential. This information is collected to identify patterns that could help to better understand what symptoms and issues may be commonly shared by others. Carnicom Institute hopes that this process will be important to advance science and improve society.

I may choose to stop and exit this questionnaire at any time by clicking the "Exit and clear survey" button located at the bottom of every page. This action will remove any results that have been entered. At any time prior to publishing survey results, my submitted information can be removed by request.

Disclaimer: The Carnicom Institute is a not for profit educational and research organization. It serves the public welfare. We do not advocate any particular products, protocols, or therapies related to health or environmental safeguards. Carnicom Institute has no responsibility to respond to individual requests for information or assistance. Any information provided through this survey does not obligate Carnicom Institute to act in any way.

*

Please choose **all** that apply:

☐ I agree

[]

FAQs:

How to I benefit from this survey? Carnicom Institute hopes that this survey will help to create what is known as a "validated" questionnaire that can be used routinely by healthcare providers and individuals. After being published this information can be used by yourself and others.

When do I see the results? Our intent is to publish this information and make it available to the public as resources allow. We have the desire and intent to release this information once meaningful conclusions can be drawn. It is anticipated that information and results will be published in phases as circumstances warrant. An email address associated with your survey results will allow us to remain in contact with you.

Will this help others? This survey is a first step towards helping others. A major goal is to improve our understanding of the "Morgellons" condition and the associated symptoms.

How will this information be used? This information will be used to develop a standardized questionnaire that can help healthcare providers and individuals better under the "Morgellons" condition.

What is our policy concerning minors? Parents are required to complete the form for anyone under the age of 18.

What is the official language of this survey? American English is the official language of the survey. Other automatic tanslations may be available as a convenience, but their reliability cannot be ascertained. We invite volunteers to help translate this survey into their fluent language.

[]

Please choose **all** that apply:

☐ Check here to read the privacy policy.

[]

Privacy Policy

This privacy policy has been compiled to better serve those who are concerned with how their 'Personally identifiable information' (PII) is being used online. PII, as used in US privacy law and information security, is information that can be used on its own or with other information

to identify, contact, or locate a single person, or to identify an individual in context. Please read our privacy policy carefully to get a clear understanding of how we collect, use, protect or otherwise handle your Personally Identifiable Information in accordance with our website.

What personal information do we collect from the people that visit our blog, website or app?

During the survey, optional information may be requested such as zipcode or other demographics. All submissions are voluntary.

When do we collect information?

We collect information from you when you respond to a survey or enter information on our site.

How do we use your information?

The information collected will be used for Carnicom Institute research purposes only.

Do we use 'cookies'?

Yes. Cookies are small files that a site or its service provider transfers to your computer's hard drive through your Web browser (if you allow) that enables the site's or service provider's systems to recognize your browser and capture and remember certain information. For instance, we use cookies to help us remember and process the results of your survey while in progress. They are also used to help us understand your preferences based on previous or current site activity, which enables us to provide you with improved services. We also use cookies to help us compile aggregate data about site traffic and site interaction so that we can offer better site experiences and tools in the future.

We use cookies to:
- **Understand and save user's preferences for future visits.**

You can choose to have your computer warn you each time a cookie is being sent, or you can choose to turn off all cookies. You do this through your browser (like Internet Explorer) settings. Each browser is a little different, so look at your browser's Help menu to learn the correct way to modify your cookies.

If users disable cookies in their browser:

If you disable cookies off, some features will be disabled It will turn off some of the features that make your site experience more efficient and some of our services will not function properly.

For example, disabling cookies might result in a situation where survey data cannot be completed or stored.

Third Party Disclosure

We do not sell, trade, or otherwise transfer to outside parties your personally identifiable information.

Third party links

We do not include or offer third party products or services on our website.

COPPA (Children Online Privacy Protection Act)

When it comes to the collection of personal information from children under 13, the Children's Online Privacy Protection Act (COPPA) puts parents in control. The Federal Trade Commission, the nation's consumer protection agency, enforces the COPPA Rule, which spells out what operators of websites and online services must do to protect children's privacy and safety online.

The rights of minors are protected as specified in the Morgellons Research Project Survey and are reviewed thoroughly by the Carnicom Institute Institutional Review Board (IRB).

Fair Information Practices

The Fair Information Practices Principles form the backbone of privacy law in the United States and the concepts they include have played a significant role in the development of data protection laws around the globe. Understanding the Fair Information Practice Principles and how they should be implemented is critical to comply with the various privacy laws that protect personal information.

In order to be in line with Fair Information Practices we will take the following responsive action, should a data breach occur:
We will notify the users via in site notification as soon as possible.

We also agree to the individual redress principle, which requires that individuals have a right to pursue legally enforceable rights against data collectors and processors who fail to adhere to the law. This principle requires not only that individuals have enforceable rights against data users, but also that individuals have recourse to courts or a government agency to investigate and/or prosecute non-compliance by data processors.

Click below to acknowledge that you have read this privacy policy.

Only answer this question if the following conditions are met:
Answer was at question '3 [PrivacyRead]' ()

[]

Privacy Policy *

Please choose **all** that apply:

☐ I have read and acknowledged the privacy policy.

[]

Your unique Response ID is: {SAVEDID}

Please record this number if you wish this survey to be referenced in the future.

Introduction & Demographic

[]

Are you completing this form for yourself or for a minor?

(Parents are required to complete the survey for minors.)

Please choose **only one** of the following:

- ○ Myself
- ○ Minor

[]Age *

Only answer this question if the following conditions are met:
Answer was 'Myself' at question '7 [DemoMinor]' (Are you completing this form for yourself or for a minor? (Parents are required to complete the survey for minors.))

Only numbers may be entered in this field.
Please check the format of your answer.

Please write your answer here:

[]Age *

Only answer this question if the following conditions are met:
Answer was 'Minor' at question '7 [DemoMinor]' (Are you completing this form for yourself or for a minor? (Parents are required to complete the survey for minors.))

Only numbers may be entered in this field.
Please check the format of your answer.

Please write your answer here:

[]Gender

Please choose **only one** of the following:

- ○ Male
- ○ Female
- ○ Other

[]Ethnicity

Please choose **only one** of the following:

- ○ Caucasian
- ○ Hispanic

- African-American
- Asian
- Other

[]Country of residence *

Please choose **only one** of the following:

- Afghanistan
- Aland Islands
- Albania
- Algeria
- American Samoa
- Andorra
- Angola
- Anguilla
- Antarctica
- Antigua and Barbuda
- Argentina
- Armenia
- Aruba
- Australia
- Austria
- Azerbaijan
- Bahamas
- Bahrain
- Bangladesh
- Barbados
- Belarus
- Belgium
- Belize
- Benin
- Bermuda
- Bhutan
- Bolivia Plurinational State of
- Bosnia and Herzegovina
- Botswana

- Bouvet Island
- Brazil
- British Indian Ocean Territory
- Brunei Darussalam
- Bulgaria
- Burkina Faso
- Burundi
- Cambodia
- Cameroon
- Canada
- Cape Verde
- Cayman Islands
- Central African Republic
- Chad
- Chile
- China
- Christmas Island
- Cocos (Keeling) Islands
- Colombia
- Comoros
- Congo
- Congo the Democratic Republic of the
- Cook Islands
- Costa Rica
- C
- Croatia
- Cuba
- Cyprus
- Czech Republic
- Denmark
- Djibouti
- Dominica
- Dominican Republic
- Ecuador
- Egypt

- El Salvador
- Equatorial Guinea
- Eritrea
- Estonia
- Ethiopia
- Falkland Islands (Malvinas)
- Faroe Islands
- Fiji
- Finland
- France
- French Guiana
- French Polynesia
- French Southern Territories
- Gabon
- Gambia
- Georgia
- Germany
- Ghana
- Gibraltar
- Greece
- Greenland
- Grenada
- Guadeloupe
- Guam
- Guatemala
- Guernsey
- Guinea
- Guinea-Bissau
- Guyana
- Haiti
- Heard Island and McDonald Islands
- Holy See (Vatican City State)
- Honduras
- Hong Kong
- Hungary

- Iceland
- India
- Indonesia
- Iran Islamic Republic of
- Iraq
- Ireland
- Isle of Man
- Israel
- Italy
- Jamaica
- Japan
- Jersey
- Jordan
- Kazakhstan
- Kenya
- Kiribati
- Korea Democratic People s Republic of
- Korea Republic of
- Kuwait
- Kyrgyzstan
- Lao People s Democratic Republic
- Latvia
- Lebanon
- Lesotho
- Liberia
- Libyan Arab Jamahiriya
- Liechtenstein
- Lithuania
- Luxembourg
- Macao
- Macedonia the former Yugoslav Republic of
- Madagascar
- Malawi
- Malaysia
- Maldives

- Mali
- Malta
- Marshall Islands
- Martinique
- Mauritania
- Mauritius
- Mayotte
- Mexico
- Micronesia Federated States of
- Moldova Republic of
- Monaco
- Mongolia
- Montenegro
- Montserrat
- Morocco
- Mozambique
- Myanmar
- Namibia
- Nauru
- Nepal
- Netherlands
- Netherlands Antilles
- New Caledonia
- New Zealand
- Nicaragua
- Niger
- Nigeria
- Niue
- Norfolk Island
- Northern Mariana Islands
- Norway
- Oman
- Pakistan
- Palau
- Palestinian Territory Occupied

- Panama
- Papua New Guinea
- Paraguay
- Peru
- Philippines
- Pitcairn
- Poland
- Portugal
- Puerto Rico
- Qatar
- REunion
- Romania
- Russian Federation
- Rwanda
- Saint BarthElemy
- Saint Helena
- Saint Kitts and Nevis
- Saint Lucia
- Saint Martin (French part)
- Saint Pierre and Miquelon
- Saint Vincent and the Grenadines
- Samoa
- San Marino
- Sao Tome and Principe
- Saudi Arabia
- Senegal
- Serbia
- Seychelles
- Sierra Leone
- Singapore
- Slovakia
- Slovenia
- Solomon Islands
- Somalia
- South Africa

- South Georgia and the South Sandwich Islands
- Spain
- Sri Lanka
- Sudan
- Suriname
- Svalbard and Jan Mayen
- Swaziland
- Sweden
- Switzerland
- Syrian Arab Republic
- Taiwan Province of China
- Tajikistan
- Tanzania United Republic of
- Thailand
- Timor-Leste
- Togo
- Tokelau
- Tonga
- Trinidad and Tobago
- Tunisia
- Turkey
- Turkmenistan
- Turks and Caicos Islands
- Tuvalu
- Uganda
- Ukraine
- United Arab Emirates
- United Kingdom
- United States
- United States Minor Outlying Islands
- Uruguay
- Uzbekistan
- Vanuatu
- Venezuela Bolivarian Republic of
- Viet Nam

- Virgin Islands British
- Virgin Islands U.S.
- Wallis and Futuna
- Western Sahara
- Yemen
- Zambia
- Zimbabwe
- Other

[]State (USA):

Only answer this question if the following conditions are met:
Answer was ' United States' at question '12 [DemoCountry]' (Country of residence)

Please choose **only one** of the following:

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts

- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

[]Zipcode

Only answer this question if the following conditions are met:
Answer was ' United States' at question '12 [DemoCountry]' (Country of residence)

Only numbers may be entered in this field.
Please check the format of your answer.

Please write your answer here:

General Health

[]How would you rate your general state of health, on a scale from 1 to 5?

Please choose **only one** of the following:

- 1
- 2
- 3
- 4
- 5

1 = poor health, 5 = excellent health

[]What has been the pattern of your health picture over the past few years?

Please choose **only one** of the following:

- stable
- improving
- declining

[]How content are you with your present general health?

Please choose **only one** of the following:

- Very content
- Somewhat content
- Disappointed in present health

[]How often do you use tobacco of any kind?

Please choose **only one** of the following:

- none
- rarely
- moderately
- regularly
- excessively

[]How often to you drink alcohol?

Please choose **only one** of the following:

- none
- rarely
- moderately

- regularly
- excessively

[]Do you take any over-the-counter drugs, vitamins, minerals, or herbal supplements?

Please choose **only one** of the following:

- Yes
- No

[]Please list any of the above and their effectiveness.

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '20 [OTCDrugs]' (Do you take any over-the-counter drugs, vitamins, minerals, or herbal supplements?)

Please write your answer here:

[]Do you take any prescription drugs?

Please choose **only one** of the following:

- Yes
- No

[]Please list any of the above and their effectiveness.

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '22 [RxDrugs]' (Do you take any prescription drugs?)

Please write your answer here:

[]Do you take any recreational drugs?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please list any of the above and their effectiveness.

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '24 [RecDrugs]' (Do you take any recreational drugs?)

Please write your answer here:

[]How often do you exercise?

Please choose **only one** of the following:

- ○ none
- ○ rarely
- ○ moderately
- ○ regularly
- ○ heavily

Skin & Nails

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 16

Any materials or substances emerging from the skin

Any materials can be seen or felt just beneath the skin surface

Open and/or slow healing lesions

Pimples or acne

Rashes or other skin conditions

Unusual appearance or changes in skin texture

Loss or increase of skin pigmentation

Any observations of unusual pigments or florescence on the skin. This includes the use of visible light, ultraviolet light, or any other means.

Excessive or unusual sweating

Any coatings, layers, or films on the surface of the skin

Unusual apperance or behavior of fingernails and/or toenails

Ingrown hair

Any unusual variations or characteristics of body hair

A sensation of motion on or under the skin

Have you ever observed or recorded any definite motion of any object or structure extracted from the skin?

Painful or irritating sensations on the skin

[]Do you have any known, identified, or diagnosed conditions involving the skin?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '28 [SkinConditions]' (Do you have any known, identified, or diagnosed conditions involving the skin?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '30 [SkinTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding skin conditions.

Please write your answer here:

Head & Hair

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 9

Itchy Scalp

Anything unusual or abnormal on the surface of the scalp

Unusual loss or growth of hair

Any unusual growth or characteristics of the hair follicles

Any unusual changes in color, texture, or structure in or within the hair

Anything unusual or abnormal underneath the scalp

Any unusual observations or sensations of movement on or under the scalp

Any unusual or abnormal growth/loss or characteristics of facial hair (e.g. eyebrows, eyelashes, beard, etc.)

Unusual headaches or migraines

[]Do you have any known, identified, or diagnosed conditions involving the head or hair?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '34 [HairConditions]' (Do you have any known, identified, or diagnosed conditions involving the

head or hair?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '36 [HairTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding conditions of the head and/or hair.

Please write your answer here:

Eyes & Vision

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 7

Excessive irritation of eyes

Any observations of unusal appearance in or around the eyes (eg. redness, dark circles, etc.)

Any unusual changes in the quality of your vision (e.g. blurry or fatigued vision)

Unusual deterioration of vision

Any unusual discharge of mucus or other fluids from the eyes

Any unusual structures or objects in or around the eyes

Any unusual sensitivities to light or darkness

[]Do you have any known, identified, or diagnosed conditions involving the eyes?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '40 [EyesConditions]' (Do you have any known, identified, or diagnosed conditions involving the eyes?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '42 [EyesTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding eye conditions.

Please write your answer here:

Ears & Hearing

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 7

Any unusual changes in hearing, such hearing loss or increased sensitivity

Any unusual irritation in or around the ears

Any unusual earaches or infections, including chronic conditions

Any unusual discharge from or blockage within the ear canal

Unusual and chronic ringing or other sensations in the ears

Any unusual structures or objects in or around the ear

Any unusual balance or orientation issues, such as vertigo

[]Do you have any known, identified, or diagnosed conditions involving the ears or hearing?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '46 [EarsConditions]' (Do you have any known, identified, or diagnosed conditions involving the ears or hearing?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '48 [EarsTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding conditions of the ears or hearing.

Please write your answer here:

Nose & Sinuses

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 8

Any change in the sense of smell.

Allergies or Hay Fever

Chronic sinus congestion

Excessive sneezing

Excessive mucus formation or discharge

Any unusual growth or objects in or around the nose

Any unusual irritation in or around the nose

Any unusual motion seen or felt in or around the nose

[]Do you have any known, identified, or diagnosed conditions involving the nose or sinuses?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '52 [NoseConditions]' (Do you have any known, identified, or diagnosed conditions involving the nose or sinuses?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '54 [NoseTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding nose or sinus conditions.

Please write your answer here:

Mouth & Throat

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 9

Any unusual dental conditions

Any notable distinctions or differences between the upper and lower teeth

Any unusual sensations of motion in or around the teeth

Any unusual objects or materials in or around the teeth

Any observations of unusual pigments, florescence, or discoloration within the mouth. This includes the use of visible light, ultraviolet light, or any other means.

Any unusual materials or structures extracted from the mouth or the teeth

Any unusual mucus or film layers observed or produced within the mouth

Any unusual observations or conditions involving the gums

Any unusual irritation or sensitivity in or around the mouth

[]Have you had your tonsils removed?

Please choose **only one** of the following:

- Yes
- No

[]Do you have any known, identified, or diagnosed conditions involving the mouth or throat?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '59 [MouthConditions]' (Do you have any known, identified, or diagnosed conditions involving the mouth or throat?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '61 [MouthTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding conditions of the mouth or throat.

Please write your answer here:

Cardiovascular

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 13

Abnormal pulse

Poor wound healing

Discoloration

Fatigue

Dizziness

Fainting

Cramps (e.g. leg)

Headaches

Chest pain

High or low blood pressure

Shortness of breath

Rapid heart rate

Unusual appearance of veins

[]Do you have any known, identified, or diagnosed conditions involving the cardiovascular system?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '65 [CardioConditions]' (Do you have any known, identified, or diagnosed conditions involving the cardiovascular system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '67 [CardioTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Do you know your bloodtype?

Please choose **only one** of the following:

- Yes
- No

[]What is your blood type?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '69 [BloodType]' (Do you know your bloodtype?)

Please choose **only one** of the following:

- A-
- A+
- B-
- B+
- AB-
- AB+
- O-
- O+

[]Have you ever observed or recorded your blood under a microscope?

Please choose **only one** of the following:

- Yes
- No

[]Do you have any records of laboratory blood tests within the last year?

Please choose **only one** of the following:

- Yes
- No

[]Please provide any additional information you wish regarding cardiovascular conditions.

Please write your answer here:

Respiratory

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 14

Difficulty breathing

Rapid breathing

Shallow breathing

Deep breathing

Pauses in breathing

Shortness of breath

Persistent cough

Chronic bronchitis

Occasional or recurring bronchitis

Asthma

Emphysema

Persistent or excessive mucus or sputum production

Cough associated with eating

Chest or lung pains

[]Do you have any known, identified, or diagnosed conditions involving the lungs or respiratory system?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '75 [RespireConditions]' (Do you have any known, identified, or diagnosed conditions involving the lungs or respiratory system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '77 [RespiratoryTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding respiratory conditions.

Please write your answer here:

Musculoskeletal

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 18

Stiffness in joints

Chronic pain in muscles or joints

Arthritis or pain in joints

Fatigue

Sleep disturbances

Twitching muscles or involuntary movement

Weakness in muscles

Pain in spine or back

Cracking or popping in joints

Bone pain

Muscle pain

Tendon & ligament pain

Neck pain

Pain in extremities

Swollen feet or legs

Tingling or numbness sensations

Tremors

Cramping

[]Do you have any known, identified, or diagnosed conditions involving the musculoskeletal system?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '81 [MuscleConditions]' (Do you have any known, identified, or diagnosed conditions involving the musculoskeletal system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '83 [MusclesTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding musculoskeletal conditions.

Please write your answer here:

Digestive System

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 29

Diarrhea

Constipation

Heartburn

Nausea

Bloating

Unusual weight gain

Inability to digest certain foods

Abdominal pain

Stomach ache/cramps

Indigestion

Ulcers

Flatulence or belching

Food allergies

Gall stones or gall bladder problems

Kidney stones

Hernia

Hemorrhoids

Urinary or stool problems

Passing of blood

Confusion

Extreme fatigue

Fainting

Fever

Vomiting

Weakness

Dizziness

Difficulty thinking and understanding

Low grade fever

Cramping

[]Do you have any known, identified, or diagnosed conditions involving the digestive system?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '87 [DigestiveConditions]' (Do you have any known, identified, or diagnosed conditions involving the digestive system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '89 [DigestiveTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding digestive conditions.

Please write your answer here:

Endocrine System

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 26

Fatigue

Anxiety, nervousness, and irritability

Unexplained weight gain or difficulty losing weight

Increased sensitivity to cold

Frequent, loose bowel movements

Constipation

Dry skin

Difficulty sleeping

Impaired memory

Thinning hair, dry or brittle hair, or hair loss

Double vision

Thinning or vanishing eyebrow

Puffy face

Irregular heart beat (arrhythmia), especially in older adults

Hoarseness

Muscle weakness

Rapid heartbeat, usually over 100 beats per minute

Elevated blood cholesterol level

Shaky hands

Muscle aches, tenderness and stiffness

Pain, stiffness, or swelling in your joints

Sweating

Slowed heart rate

Weight loss despite increased appetite

Increased appetite

Night sweats

[]

Average body temperature, if known

Please choose **only one** of the following:

- ○ Low
- ○ Normal

- ○ High

[]Do you have any known, identified, or diagnosed conditions involving the thyroid, hormones, and/or glands?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '94 [EndocrineConditions]' (Do you have any known, identified, or diagnosed conditions involving the thyroid, hormones, and/or glands?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '96 [EndocrineTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding the thyroid, hormones, and/or glands.

Please write your answer here:

Neurological System

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 27

Headaches

Blurry vision

Dry eyes and mouth

Poor cognitive abilities

Partial or complete loss of sensation or senses

Poor concentration

Speech problems

Muscle weakness

Fatigue

Sleep problems

Difficulty reading and writing

Learning difficulties

Decreased alertness

Slurred speech

Trouble moving

Swallowing

Tremors

Changes in coordination or balance

Numbness in extremities

Unexplained pain, such as sharp radiating pain

Dizziness

Unusual sweating

Epilepsy / seizures

Partial or complete paralysis

Constipation

Bladder dysfunction

Sexual dysfunction

[]Do you have any known, identified, or diagnosed conditions involving the nervous system?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '100 [NervousConditions]' (Do you have any known, identified, or diagnosed conditions involving the nervous system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '102 [NervousTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding neurological conditions.

Please write your answer here:

Cognitive & Psychological

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 33

Forget events

Reliance on external memory aides such as calenders and notes

Loss of train of thought or flow of thread of conversations

Overwhelmed by making decisions

Difficulty finding words

Difficulty in organizing or planning

Difficulty managing normal daily routines

Difficulty managing bills and accounts

Difficulty finding your way around familiar environments

Difficulty in maintaining interest or passion in hobbies

Tendency to misplace things

More impulsive, showing poor judgement

Your family and friends are noticing these changes

Mild depression

Groggy, unclear thinking (brain fog)

Close personal relationships have been significantly affected

Noticing unusual, exotic, complicated or meaningful patterns that others do not necessarily observe.

Mild memory loss or forgetfulness

A change in aggression levels

A change in irritability levels

Important working relationships have been significantly affected

A change in anxiety levels

A change in apathy levels

Severe memory loss or forgetfulness

Severe depression

Difficulty concentrating

A change in learning ability

Unexplained confusion

A tendency towards irrational, illogical, or unsound thinking patterns

Unwarranted or unexplained fears

Inability to focus

Writing and especially spelling becomes difficult

Mood swings

[]Do you have any known, identified, or diagnosed cognitive or psychological conditions?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '106 [CognitiveConditions]' (Do you have any known, identified, or diagnosed cognitive or psychological conditions?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '108 [CognitiveTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding cognitive or psychological conditions.

Please write your answer here:

Immune System

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 25

Frequently sick

Difficulty diagnosing, identifying, or explaining the illness

Joint problems

Arthritis

Muscle problems

Skin problems

Allergies

Asthma

Fatigue

Numbness and tingling

Vision problems

Severe dental cavities

Frequent fevers

Weight loss

Weight gain

Constipation / diarrhea

Nervous disorders

Loss of or changes in hair growth

Rashes, hives, or skin conditions

Memory problems

Changes in behavior

Mouth sores

Persistent infections

Undue stress

Symptoms come and go

[]Do you have any known, identified, or diagnosed conditions involving the immune system?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '112 [ImmuneConditions]' (Do you have any known, identified, or diagnosed conditions involving the immune system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '114 [ImmuneTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Have you encountered difficulty having your symptoms acknowleged, recognized, or diagnosed over a prolonged period of time?

Please choose **only one** of the following:

- Yes

○ No

[]Please provide the details.

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '116 [ImmuneDifficulty]' (Have you encountered difficulty having your symptoms acknowleged, recognized, or diagnosed over a prolonged period of time?)

Please write your answer here:

[]Please provide any additional information you wish regarding immune system conditions.

Please write your answer here:

Reproductive System

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

Only answer this question if the following conditions are met:
Answer was 'Other' *or* 'Female' at question '10 [DemoGender]' (Gender)

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 21

Menstrual irregularity

Monthly weight gain

Depression

Moodiness/irritability

Bloating and swelling

Nausea and/or vomiting

Anxiety

Headaches

Easily distracted

Anger

Tender breasts

Low backache

Suicidal feeling

Asthma attacks

Vaginal itching

Vaginal discharge

Low or no desire for sex

Miscarriages

Urinary tract infection

Vaginal dryness

Hot flashes

[]

Do you have any of the following symptoms?

Only move the symptoms that you are experiencing.

Items can be reordered or moved around as needed.

Only answer this question if the following conditions are met:
Answer was 'Male' *or* 'Other' at question '10 [DemoGender]' (Gender)

All your answers must be different and you must rank in order.

Please number each box in order of preference from 1 to 16

Difficulty urinating

A sense of bladder fullness

Increased straining with smaller amounts of urine passed

Rose colored (bloody) urine

Pain or burning while urinating

Frequently wake up to urinate at night

Dripping after urination

Pain or fatigue in the legs or back

Lack of sex drive

Ejaculation causes pain

Difficulty attaining and/or maintaining an erection

Low sexual drive

Premature ejaculation

Pain/coldness in genital area

Varicose veins on scrotum

Urinary tract infection

[]Do you have any known, identified, or diagnosed conditions involving the reproductive system?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '121 [ReproConditions]' (Do you have any known, identified, or diagnosed conditions involving the reproductive system?)

Please write your answer here:

[]Have you ever been treated by anyone for any of the listed symptoms?

Please choose **only one** of the following:

- Yes
- No

[]

Which ones were you treated for?

What methods of treatment were used?

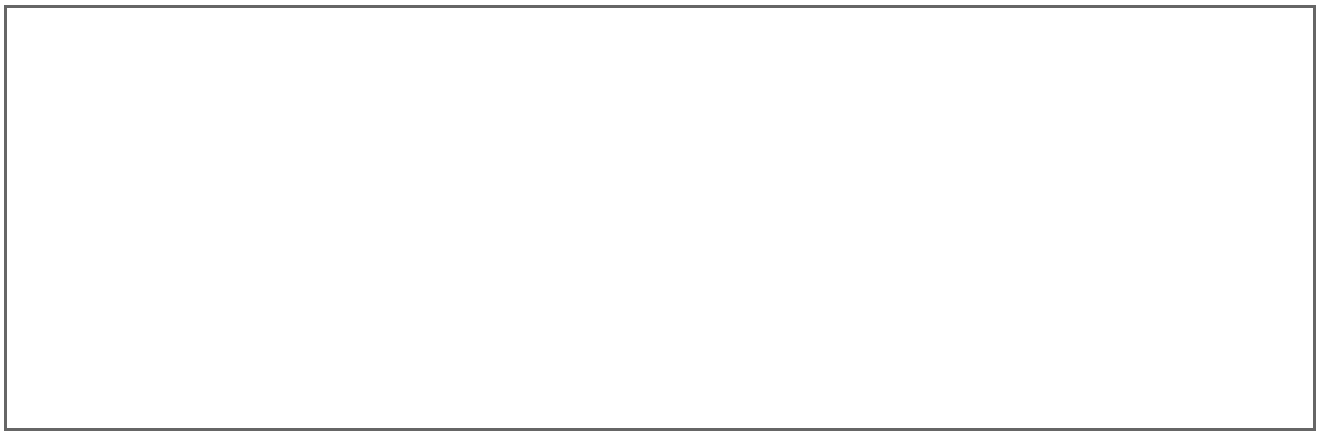
What were the results?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '123 [ReproTreatment]' (Have you ever been treated by anyone for any of the listed symptoms?)

Please write your answer here:

[]Please provide any additional information you wish regarding reproductive conditions..

Please write your answer here:



"Morgellons" & Associated Conditions

[]

The following list may or may not represent associated conditions related to the "Morgellons" condition.

Have you ever been examined or diagnosed for any of these following conditions?

Please choose **all** that apply:

- ☐ Lyme disease
- ☐ Spirochete infection
- ☐ Borellia infection
- ☐ Babesia infection
- ☐ Erlichia infection
- ☐ Bartonella infection
- ☐ Anaplasma infection
- ☐ Delusional parasitosis or delusional infestation
- ☐ Bovine digital dermititis
- ☐ Agrobacterium infection
- ☐ Unexplained dermopathy
- ☐ Chlamydia
- ☐ Association and/or contact with external organisms, eg. insects, arthropods, etc.
- ☐ Chronic fatigue
- ☐ Fibromyalgia
- ☐ Autism
- ☐ Dyslexia
- ☐ Herpes (eg. shingles)
- ☐ Multiple Sclerosis
- ☐ Amyotrophic Lateral Sclerosis (ALS / Lou Gehrig's Disease)
- ☐ Lupus
- ☐ Restless leg syndrome
- ☐ Gulf War syndrome
- ☐ Parkinson's Disease
- ☐ Any other clinical diagnosis or condition (describe below if checked)

[]Please describe

Only answer this question if the following conditions are met:
Answer was at question '126 [AssociatedList]' (The following list may or may not represent associated conditions related to the "Morgellons" condition. Have you ever been examined or diagnosed for any of these following conditions?)

Please write your answer here:

[]Would you consider yourself to be afflicted with what has been referred to as "Morgellons Disease"?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Have you been involved in any formal studies of the "Morgellons" condition or any of the associated conditions above?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please provide details

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '129 [AssociatedStudies]' (Have you been involved in any formal studies of the "Morgellons" condition or any of the associated conditions above?)

Please write your answer here:

[]Formal diagnosis results

Please choose **all** that apply:

- ☐ Have you been diagnosed with any of the above conditions?
- ☐ Do you agree with any of the diagnoses?
- ☐ Do you disagree with any of the diagnoses?

[]

Which ones were you diagnosed with?

Why or why not do you agree with each diagnosis?

Please write your answer here:

[]Has any diagnosis received affected your personal or professional life in any significant fashion?

Please choose **only one** of the following:

- Yes
- No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '133 [DiagnosisAffected]' (Has any diagnosis received affected your personal or professional life in any significant fashion?)

Please write your answer here:

[]Estimate the number of affected family, friends, or associates showing symptoms that are similar to what you have..

Only an integer value may be entered in this field.

Please write your answer here:

[]If desired, please describe any special circumstances or conditions.

Only answer this question if the following conditions are met:

Answer was greater than '0' at question '135 [NumberSimilar]' (Estimate the number of affected family, friends, or associates showing symptoms that are similar to what you have..)

Please write your answer here:

[]Are any of your symptoms more severe at any time of the day?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Which time of day are your symptoms more severe?

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '137 [TimeOfDay]' (Are any of your symptoms more severe at any time of the day?)

Please choose **only one** of the following:

- ○ morning
- ○ afternoon
- ○ evening
- ○ night

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '137 [TimeOfDay]' (Are any of your symptoms more severe at any time of the day?)

Please write your answer here:

[]Please provide any additional information you wish regarding "Morgellons" or associated conditions.

Please write your answer here:

Environmental

[]You live in this setting:

Please choose **only one** of the following:

- ○ inner city
- ○ suburban
- ○ rural

[]Do you know of any unusual or noteworthy environmental factors that may be affecting your health situation?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '142 [EnvFactors]' (Do you know of any unusual or noteworthy environmental factors that may be affecting your health situation?)

Please write your answer here:

250 characters maximum

[]Have you ever been or are you currently exposed to or associated with persons showing unusual symptoms or conditions?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please describe:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '144 [EnvSocial]' (Have you ever been or are you currently exposed to or associated with persons showing unusual symptoms or conditions?)

Please write your answer here:

250 characters maximum

[]Have you been or are you currently exposed to toxins, irritants, chemicals, allergens, etc.?

Please choose **only one** of the following:

- ○ Yes
- ○ No

[]Please indicate what you were exposed to, how this exposure happened, and when the exposure occurred:

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '146 [EnvironToxins]' (Have you been or are you currently exposed to toxins, irritants, chemicals, allergens, etc.?)

Please write your answer here:

250 characters maximum

Free Response

[]Please describe anything you like here, such as your health strategies, etc. Any comments relevant to this survey or the subject material are welcome.

Please write your answer here:

Submit

[]

You are finished with the survey!

Make sure to click the SUBMIT button at the bottom of this page.

[]

Please tell us anything that you liked or did not like about this survey experience.

Please write your answer here:

[]

Special thanks and acknowledgments

Carnicom Institute would like to bring attention to all of the individuals whose work has been influential in the creation of this survey. This is includes, but is not limited to, experts in various medical fields, independent journalists, Internet communications specialists, and many other professionals, as well as countless laypersons. Acknowledgment is given to the hard work and effort that has proceeded this public offering. We give our deepest thanks and appreciation to anyone who contributed to this project, you know who you are.

The technology that supports this project

This survey has been made possible by the following software and services. This list is by no means exhaustive, and is just meant to highlight some of the more important tools used in the creation process.

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The hosting is paid for entirely with donated Bitcoin.
The theme is a modified version of "citronade" and is subject to the GNU Public License (GPL).

If you like what you see, then by all means, LetMeBuildYour.Website !

Thank you for participating in the MRP Symptom Survey. These results will be included in future phases of the MRP. You will be contacted again when that phase begins.

Submit your survey.
Thank you for completing this survey.