

VOLUNTEER MEDICAL APPLICATION

HEALTH STATUS REVIEW

Version 3.1

Please complete this Health Status Review and submit it at the same time you submit your Peace Corps Application. Use the enclosed envelope which is labeled "Medical Information Envelope". If the envelope is missing use a plain envelope, write "Medical History" on it, seal it, and send it with your application.



Before you can be accepted to serve overseas, Peace Corps needs to assess your health. This Health Status Review Form is the first step in the medical review process. It will take about 15 minutes to complete the form. Your signature at the end of the form certifies that you have answered all questions accurately and completely.

A MEDICAL HISTORY FOR INTERNATIONAL PLACEMENT

A health condition you manage easily at home in the U.S. can become a significant medical issue in the countries Peace Corps serves. The Peace Corps Office of Medical Services assesses your health in the context of living conditions and medical care available in each country.

For these reasons the types of medical questions asked and their level of detail are unlike medical histories normally used for U.S. based health care.

The Applicant Medical Screening Process is thorough, and it is important for you to answer these questions accurately. You should know that we are able to medically clear more than 85% of all Applicants who complete the Medical Screening Process.

INSTRUCTIONS

Be sure to answer all questions.

Fill in all dates where it is appropriate to do so.

Fill in all bubbles completely.

If you are unfamiliar with a condition AND believe you may have had it, please check with your family physician or someone familiar with your medical history before answering the question.

Do not write explanatory notes on the form.

Do not send additional information about your health at this time.

Failure to answer all questions completely may mean you will have to complete a new form.

PRIVACY ACT AND PUBLIC BURDEN NOTICE - The Peace Corps is authorized by provisions of the Peace Corps Act to collect information regarding the suitability and qualifications of applicants for Peace Corps Service. The information you provide in this Health Status Review Form will be used to evaluate your suitability and qualifications to serve as a Volunteer. This form and the information you provide will be kept in a System of Records called the Volunteer Applicant and Service Record System. Because Volunteer Records have been kept according to Social Security Number (SSN) prior to 1975, we are authorized by the Privacy Act to request your SSN in order to keep your records straight. Completing this form is voluntary; if you do not give us your SSN or any other information requested, we may be unable to assess your suitability and qualifications for service. The Health Status Review Form is part of the Volunteer Application Kit consisting of this form and the Volunteer Application. The routine uses set forth in the Volunteer Application's Privacy Act Notice at Paragraph C, item 2 and Paragraph C, items 4-12 also apply to this form. In addition, information from the Health Status Review Form may be routinely disclosed in connection with claims under the Federal Employee's Compensation Act, to medical personnel treating or involved in the treatment or care of an applicant, Trainee, or Volunteer and to the U.S. Ambassador or his/her designee in Peace Corps countries, but only upon written certification that the information is needed to perform an official responsibility. OMB 0420-0510

MARKING INSTRUCTIONS

- Use a No. 2 pencil only. Do not use pen.
- Make solid marks that fill the response completely.
- Make no stray marks on this form.

Correct Mark: ● Incorrect Marks:

MARKING EXAMPLE:

Month	Day	Year
<input type="radio"/> Jan	0	3
<input type="radio"/> Feb	5	7
<input type="radio"/> Mar	0	0
<input type="radio"/> Apr	1	1
<input type="radio"/> May	2	2
<input type="radio"/> Jun	3	3
<input type="radio"/> Jul	4	4
<input type="radio"/> Aug	5	5
<input type="radio"/> Sept	6	6
<input type="radio"/> Oct	7	7
<input type="radio"/> Nov	8	8
<input type="radio"/> Dec	9	9

2. Social Security Number:
(It is very important that these bubbles be filled in completely and correctly.)

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

3. Are you:
 Female Male

4. Are you a Returned Peace Corps Volunteer?
 Yes No

1. Name: _____

(Fill in bubbles for the first three letters of your last name.)

A	A	A
B	B	B
C	C	C
D	D	D
E	E	E
F	F	F
G	G	G
H	H	H
I	I	I
J	J	J
K	K	K
L	L	L
M	M	M
N	N	N
O	O	O
P	P	P
Q	Q	Q
R	R	R
S	S	S
T	T	T
U	U	U
V	V	V
W	W	W
X	X	X
Y	Y	Y
Z	Z	Z

5. Today's Date:

Month	Day	Year
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar	0	0
<input type="radio"/> Apr	1	1
<input type="radio"/> May	2	2
<input type="radio"/> June	3	3
<input type="radio"/> July	4	4
<input type="radio"/> Aug	5	5
<input type="radio"/> Sept	6	6
<input type="radio"/> Oct	7	7
<input type="radio"/> Nov	8	8
<input type="radio"/> Dec	9	9

6. Date of Birth:

Month	Day	Year
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar	0	0
<input type="radio"/> Apr	1	1
<input type="radio"/> May	2	2
<input type="radio"/> June	3	3
<input type="radio"/> July	4	4
<input type="radio"/> Aug	5	5
<input type="radio"/> Sept	6	6
<input type="radio"/> Oct	7	7
<input type="radio"/> Nov	8	8
<input type="radio"/> Dec	9	9

7. Height in Feet and Inches: **8. Weight in Pounds:**

Feet	Inches	Pounds
	0	0
	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

9. Are you applying with your spouse?

Yes No

If YES, enter your spouse's Social Security Number.

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9



PLEASE DO NOT WRITE IN THIS AREA

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BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

ALL APPLICANTS COMPLETE

10. Have you ever smoked or used tobacco products? Yes No

If YES, do you currently smoke or use tobacco:
 every day
 some days
 former smoker only

11. Do you currently wear dental braces? Yes No
 (This does NOT include removable orthodontic retainers, dentures, partial plates or bridges.)

12. Do you have or have you ever had: Yes No
 Chronic inner ear infection (otitis media) after age 15
 Meniere's disease
 Cyst of the inner ear

If any YES in Item 12, give date of most recent symptoms or treatment.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> Apr	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> May	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> June	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> July	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> Aug	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> Sept	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> Oct	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> Nov	<input checked="" type="radio"/> <input checked="" type="radio"/>
<input type="radio"/> Dec	<input checked="" type="radio"/> <input checked="" type="radio"/>

13. Do you currently require the use of at least one hearing aid? Yes No

14. Other than tonsillectomy, childhood tonsillitis or wisdom teeth extraction, do you have any condition or have you had any surgery on your ears, nose, face, sinuses, jaw or throat not listed in Items 11-13? Yes No

15. Do you have or have you ever had: Yes No
 Glaucoma
 Herpes infection of the cornea (herpes keratitis)
 Two or more episodes of optic neuritis
 Chronic uveitis or iritis
 Cataract surgery
 Other vision correcting surgery, such as RK, PRK, LASIK
 Macular or lattice degeneration (degeneration of the retina)
 Retinal detachment

16. Other than astigmatism or use of corrective lenses, do you have or have you had any other condition or surgery of the eye not listed in Item 15? Yes No

17. Are you allergic to: Yes No
 Sulfa drugs (such as Bactrim, Septra)
 Other medication(s)
 Eggs
 Peanuts
 Shellfish
 Other food(s)
 Bee, wasp or other insect stings | Hayfever or other environmental allergies (such as grass, pollen, dust, animal hair, etc.)

18. During an allergic reaction, have you ever had: Yes No
 Difficulty breathing
 Loss of consciousness
 Severe swelling of your nose, lips, tongue or throat
 Emergency treatment in a medical facility for an allergic reaction

19. Do you have or have you ever had: Yes No
 Chronic bronchitis
 Pneumonia more than once during the last 5 years
 Emphysema or COPD
 A collapsed lung (pneumothorax)
 Removal of a lung or a lobe of the lung

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

20. Since age 15, have you ever:

	Yes	No
Experienced wheezing	<input checked="" type="radio"/> (Y)	<input type="radio"/> (N)
Used an inhaler to prevent breathing problems or to help you breathe	<input type="radio"/> (Y)	<input type="radio"/> (N)
Been told you have asthma, bronchospasm or reactive (restrictive) airway disease	<input type="radio"/> (Y)	<input type="radio"/> (N)

21. Do you have or have you had any respiratory condition, lung condition or surgery not listed in Items 19–20?

	Yes	No
	<input type="radio"/> (Y)	<input checked="" type="radio"/> (N)

22. Do you take prescription medication to control your blood pressure?

	Yes	No
	<input type="radio"/> (Y)	<input checked="" type="radio"/> (N)

23. Do you take prescription medication for high cholesterol?

	Yes	No
	<input type="radio"/> (Y)	<input checked="" type="radio"/> (N)

24. Have you ever had:

	Yes	No
Angina	<input type="radio"/> (Y)	<input checked="" type="radio"/> (N)
A heart attack	<input type="radio"/> (Y)	<input type="radio"/> (N)
Coronary artery or heart by-pass surgery	<input type="radio"/> (Y)	<input type="radio"/> (N)
Coronary angioplasty ("balloon angioplasty") or insertion of stent(s)	<input type="radio"/> (Y)	<input type="radio"/> (N)
Other heart surgery	<input type="radio"/> (Y)	<input type="radio"/> (N)
Carotid artery surgery	<input type="radio"/> (Y)	<input type="radio"/> (N)
Other surgery of the arteries	<input type="radio"/> (Y)	<input type="radio"/> (N)

25. Do you have or have you ever had:

	Yes	No
A pacemaker	<input type="radio"/> (Y)	<input type="radio"/> (N)
Coronary artery disease	<input type="radio"/> (Y)	<input type="radio"/> (N)
Congestive heart failure	<input type="radio"/> (Y)	<input type="radio"/> (N)
A disturbance of heart rhythm (arrhythmia)	<input type="radio"/> (Y)	<input type="radio"/> (N)
An aneurysm	<input type="radio"/> (Y)	<input type="radio"/> (N)

26. Do you have or have you ever had:

	Yes	No
A heart murmur present after age 15	<input type="radio"/> (Y)	<input type="radio"/> (N)
Heart valve disease	<input type="radio"/> (Y)	<input type="radio"/> (N)
Mitral valve prolapse	<input type="radio"/> (Y)	<input type="radio"/> (N)
A blood clot in the lung (pulmonary embolism)	<input type="radio"/> (Y)	<input type="radio"/> (N)
Thrombophlebitis	<input type="radio"/> (Y)	<input type="radio"/> (N)
Problems caused by poor circulation	<input type="radio"/> (Y)	<input type="radio"/> (N)

27. Other than aspirin, do you currently take any blood-thinning (anti-coagulant) medication, such as Warfarin or Coumadin?

	Yes	No
	<input type="radio"/> (Y)	<input type="radio"/> (N)

28. Do you have or have you had any other heart or circulatory condition or surgery not listed in Items 22–27?

	Yes	No
	<input type="radio"/> (Y)	<input type="radio"/> (N)

29. Do you have or have you ever had:

	Yes	No
An esophageal stricture	<input type="radio"/> (Y)	<input type="radio"/> (N)
Esophageal varices	<input type="radio"/> (Y)	<input type="radio"/> (N)
Stomach or duodenal ulcers (peptic ulcer disease)	<input type="radio"/> (Y)	<input type="radio"/> (N)
Cirrhosis of the liver	<input type="radio"/> (Y)	<input type="radio"/> (N)
Yellow jaundice (other than at birth)	<input type="radio"/> (Y)	<input type="radio"/> (N)
Pancreatic disease	<input type="radio"/> (Y)	<input type="radio"/> (N)
Diverticulosis/diverticulitis	<input type="radio"/> (Y)	<input type="radio"/> (N)
Part or all of your small or large intestine removed	<input type="radio"/> (Y)	<input type="radio"/> (N)

30. Do you now have:

	Yes	No
A hernia of the groin (inguinal) or abdomen	<input type="radio"/> (Y)	<input type="radio"/> (N)
A colostomy or an ileostomy	<input type="radio"/> (Y)	<input type="radio"/> (N)

31. Have you had two or more episodes of a cyst near the rectum (pilonidal cyst)?

	Yes	No
	<input type="radio"/> (Y)	<input type="radio"/> (N)

32. Do you have or have you had any other conditions or surgery of the esophagus, stomach, liver, gall bladder, pancreas or intestinal tract not listed in Items 29–31?

	Yes	No
	<input type="radio"/> (Y)	<input type="radio"/> (N)

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

PLEASE DO NOT WRITE IN THIS AREA



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FEMALES: GO TO ITEM 35.

MALES ONLY

33. Have you ever had:
- Difficulty starting or stopping your urine stream Yes No
 (Y) (N)
 - An enlarged prostate Yes No
 (Y) (N)
 - Pain or swelling in your testicles Yes No
 (Y) (N)
 - hydrocele, spermatocele or varicocele Yes No
 (Y) (N)
34. Do you have or have you had any other genital condition or surgery not listed in Item 33? Yes No
 (Y) (N)

End of Male Only Items

MALES: GO TO ITEM 43.

FEMALES ONLY

35. Are you currently using:
- Birth control pills Yes No
 (Y) (N)
 - Birth control implants (such as Norplant) Yes No
 (Y) (N)
 - Birth control injections (such as Depo-Provera) Yes No
 (Y) (N)
 - An intra-uterine device (IUD) Yes No
 (Y) (N)

If any YES in Item 35, give date treatment began.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	<input type="text"/> <input type="text"/>
<input type="radio"/> Apr	<input type="text"/> <input type="text"/>
<input type="radio"/> May	<input type="text"/> <input type="text"/>
<input type="radio"/> June	<input type="text"/> <input type="text"/>
<input type="radio"/> July	<input type="text"/> <input type="text"/>
<input type="radio"/> Aug	<input type="text"/> <input type="text"/>
<input type="radio"/> Sept	<input type="text"/> <input type="text"/>
<input type="radio"/> Oct	<input type="text"/> <input type="text"/>
<input type="radio"/> Nov	<input type="text"/> <input type="text"/>
<input type="radio"/> Dec	<input type="text"/> <input type="text"/>

36. Have you ever had a Pap smear? Yes No
 (Y) (N)

37. Do you have or have you ever had: Yes No
- PID (pelvic inflammatory disease) or tubal infections Yes No
 (Y) (N)
 - Uterine fibroids Yes No
 (Y) (N)
 - Endometriosis Yes No
 (Y) (N)

38. Do you currently have: Yes No
- Menstrual cycles Yes No
 (Y) (N)
 - Irregular menstrual cycles (NOT monthly) Yes No
 (Y) (N)
 - Bleeding or spotting between menstrual cycles Yes No
 (Y) (N)

39. Are you: Yes No
- Post-menopausal (NOT due to removal of uterus, or hysterectomy) Yes No
 (Y) (N)
 - Post-menopausal with any vaginal bleeding or spotting Yes No
 (Y) (N)
 - Receiving hormone replacement therapy (HRT) Yes No
 (Y) (N)

40. Have you had your uterus removed (hysterectomy)? Yes No
 (Y) (N)

41. Do you have or have you ever had: Yes No
- A breast cyst or lump Yes No
 (Y) (N)
 - Fibrocystic breast changes Yes No
 (Y) (N)
 - Breast implants Yes No
 (Y) (N)

42. Do you have or have you ever had any other gynecological conditions or surgery not listed in Items 35-41? Yes No
 (Y) (N)

End of Female Only Items

FEMALES: CONTINUE WITH ITEM 43.

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

ALL APPLICANTS COMPLETE

43. Have you had four or more bladder infections (cystitis) in the past year? Yes No

44. Have you had two or more kidney infections (pyelonephritis) in the past two years? Yes No

45. Have you had:
 A single episode of kidney stones Yes No

 Two or more episodes of kidney stones Yes No

If any YES in Item 45, give date of most recent occurrence.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	0 0
<input type="radio"/> Apr	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4 4
<input type="radio"/> Aug	5 5
<input type="radio"/> Sept	6 6
<input type="radio"/> Oct	7 7
<input type="radio"/> Nov	8 8
<input type="radio"/> Dec	9 9

46. Do you have or have you had any urinary, bladder, or kidney condition or surgery not listed in Items 43-45? Yes No

47. Do you have or have you ever had:
 Eczema or psoriasis Yes No

 Basal cell tumor(s) of the skin Yes No

 A cancerous mole or other skin cancer (NOT basal cell) Yes No

48. Do you have any other skin condition not listed in Item 47 for which you are taking prescription medication or receiving medical treatment? Yes No

49. Have you ever broken any of the following bones? Yes No
 Back (spine) or neck
 Hip
 Skull
 Pelvis

If any YES in Item 49, give date of injury.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	0 0
<input type="radio"/> Apr	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4 4
<input type="radio"/> Aug	5 5
<input type="radio"/> Sept	6 6
<input type="radio"/> Oct	7 7
<input type="radio"/> Nov	8 8
<input type="radio"/> Dec	9 9

50. Do you have or have you ever been medically treated or had surgery for: Yes No
 Chronic or recurrent neck or back pain (excluding arthritis)
 Pinched nerve(s)
 A disc problem
 Scoliosis or kyphosis

If any YES in Item 50, give date of most recent treatment or surgery.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	0 0
<input type="radio"/> Apr	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4 4
<input type="radio"/> Aug	5 5
<input type="radio"/> Sept	6 6
<input type="radio"/> Oct	7 7
<input type="radio"/> Nov	8 8
<input type="radio"/> Dec	9 9

51. Other than for arthritis or bursitis, have you been medically treated more than twice for: Yes No
 Chronic shoulder pain, dislocation or rotator cuff injury
 Chronic hip pain
 Chronic knee pain
 Chronic ankle pain (excluding uncomplicated ankle strains or sprains)

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

52. Have you ever had:
- Shoulder arthroscopy, ligament repair, reconstruction or replacement Yes No
 - Hip reconstruction or replacement Yes No
 - Knee arthroscopy, ligament repair, reconstruction or replacement Yes No
 - Orthopedic hardware (pins, plates, rods, screws, etc.) left in place Yes No

If any YES in Item 52, give date of most recent surgery.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	<input type="text" value="0"/> <input type="text" value="0"/>
<input type="radio"/> Apr	<input type="text" value="1"/> <input type="text" value="1"/>
<input type="radio"/> May	<input type="text" value="2"/> <input type="text" value="2"/>
<input type="radio"/> June	<input type="text" value="3"/> <input type="text" value="3"/>
<input type="radio"/> July	<input type="text" value="4"/> <input type="text" value="4"/>
<input type="radio"/> Aug	<input type="text" value="5"/> <input type="text" value="5"/>
<input type="radio"/> Sept	<input type="text" value="6"/> <input type="text" value="6"/>
<input type="radio"/> Oct	<input type="text" value="7"/> <input type="text" value="7"/>
<input type="radio"/> Nov	<input type="text" value="8"/> <input type="text" value="8"/>
<input type="radio"/> Dec	<input type="text" value="9"/> <input type="text" value="9"/>

53. Do you have arthritis or bursitis that requires the use of prescription medication? Yes No
54. Do you have or have you ever had:
- Repetitive motion injury/syndrome Yes No
 - Carpal tunnel syndrome Yes No
55. Do you currently have painful bunions? Yes No
56. Do you have or have you had any other joint, muscle or bone condition or surgery not listed in Items 49–55? Yes No

57. Do you have or have you ever had:
- Fibromyalgia Yes No
 - Ankylosing spondylitis Yes No
 - Rheumatoid arthritis Yes No
 - Juvenile rheumatoid arthritis Yes No
 - Reiter's Syndrome (either single or multiple episodes) Yes No

58. Do you currently have:
- Iron deficiency anemia Yes No
 - A folate deficiency Yes No
 - A Vitamin B-12 deficiency (pernicious anemia) Yes No
 - A low platelet count (thrombocytopenia) Yes No
 - A missing spleen (due to surgery) Yes No
 - Hemochromatosis Yes No
 - Sickle cell disease, with symptoms Yes No
 - Thalassemia disease, with symptoms Yes No
 - A clotting disorder Yes No
 - Polycythemia vera Yes No
 - Systemic lupus erythematosus (SLE) Yes No

59. Do you have any other blood, immune system, connective tissue or collagen condition not listed in Items 57–58? Yes No

60. Do you have diabetes? Yes No

61. Do you have gout? Yes No

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

PLEASE DO NOT WRITE IN THIS AREA



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62. Do you have or have you ever had:
- | | | |
|---|----------------------------------|----------------------------------|
| A thyroid goiter | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| A thyroid nodule | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| An overactive thyroid (hyperthyroidism) | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| An underactive thyroid (hypothyroidism) | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Other thyroid disease | <input checked="" type="radio"/> | <input checked="" type="radio"/> |

If any YES in Item 62, give date of most recent treatment.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	<input type="radio"/> 0 <input type="radio"/> 0
<input type="radio"/> Apr	<input type="radio"/> 1 <input type="radio"/> 1
<input type="radio"/> May	<input type="radio"/> 2 <input type="radio"/> 2
<input type="radio"/> June	<input type="radio"/> 3 <input type="radio"/> 3
<input type="radio"/> July	<input type="radio"/> 4 <input type="radio"/> 4
<input type="radio"/> Aug	<input type="radio"/> 5 <input type="radio"/> 5
<input type="radio"/> Sept	<input type="radio"/> 6 <input type="radio"/> 6
<input type="radio"/> Oct	<input type="radio"/> 7 <input type="radio"/> 7
<input type="radio"/> Nov	<input type="radio"/> 8 <input type="radio"/> 8
<input type="radio"/> Dec	<input type="radio"/> 9 <input type="radio"/> 9

63. Do you have or have you ever had a disease of the pituitary gland? Yes No

64. Do you have or have you had any other condition of the endocrine system not listed in Items 60–63? Yes No

65. Did you ever have a blood transfusion before July 1992? Yes No

66. Have you ever been exposed to Hepatitis C virus (HCV) by injury, accidental needlestick, injection of drugs (even once), or because your mother had Hepatitis C virus when you were born? Yes No

67. Do you have or have you ever had (this does NOT refer to immunizations):
- | | | |
|-------------------|----------------------------------|----------------------------------|
| Hepatitis A virus | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Hepatitis B virus | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Hepatitis C virus | <input checked="" type="radio"/> | <input checked="" type="radio"/> |

68. Do you have or have you ever had:
- | | | |
|--|----------------------------------|----------------------------------|
| Chronic fatigue syndrome | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| A positive skin test for tuberculosis | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Active tuberculosis disease of the lungs or other organs | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Lyme disease | <input checked="" type="radio"/> | <input checked="" type="radio"/> |

69. Other than a cold or the flu, do you currently have any other infectious or parasitic condition not listed in Items 65–68? Yes No

70. Do you have severe or migraine headaches that require prescription medication? Yes No

71. Have you ever had any seizures or convulsions? Yes No

If YES, did they occur prior to age 5, and were they associated with high fever?

72. Have you ever had a stroke or stroke-like symptoms? Yes No

73. Do you have:
- | | | |
|--------------------|----------------------------------|----------------------------------|
| Cerebral Palsy | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Multiple Sclerosis | <input checked="" type="radio"/> | <input checked="" type="radio"/> |

74. Do you have or have you had any other neurological or nervous system condition or surgery not listed in Items 70–73? Yes No

75. Do you have or have you ever had:
- | | | |
|---|----------------------------------|----------------------------------|
| Leukemia or lymphoma | <input checked="" type="radio"/> | <input checked="" type="radio"/> |
| Any other type of cancer or malignant tumor not previously noted on this form | <input checked="" type="radio"/> | <input checked="" type="radio"/> |

If any YES in Item 75, give date of most recent occurrence or treatment.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	<input type="radio"/> 0 <input type="radio"/> 0
<input type="radio"/> Apr	<input type="radio"/> 1 <input type="radio"/> 1
<input type="radio"/> May	<input type="radio"/> 2 <input type="radio"/> 2
<input type="radio"/> June	<input type="radio"/> 3 <input type="radio"/> 3
<input type="radio"/> July	<input type="radio"/> 4 <input type="radio"/> 4
<input type="radio"/> Aug	<input type="radio"/> 5 <input type="radio"/> 5
<input type="radio"/> Sept	<input type="radio"/> 6 <input type="radio"/> 6
<input type="radio"/> Oct	<input type="radio"/> 7 <input type="radio"/> 7
<input type="radio"/> Nov	<input type="radio"/> 8 <input type="radio"/> 8
<input type="radio"/> Dec	<input type="radio"/> 9 <input type="radio"/> 9

76. Are you recovering from alcohol abuse or substance abuse? Yes No

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

77. Have you ever had:
 Family counseling (such as related to marital issues) Yes No
 Support group counseling (such as for grief or divorce) Yes No

78. Other than for academic guidance counseling only, have you ever had:
 Individual counseling or consultation with a psychiatrist, psychologist or mental health counselor Yes No
 Substance abuse or alcohol abuse counseling (other than awareness counseling or classes related to traffic citations) Yes No

If any YES in Item 78, give date of last counselling session. (NOTE: Failure to provide date, if counseled, will delay processing of your application.)

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	0 0
<input type="radio"/> Apr	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4 4
<input type="radio"/> Aug	5 5
<input type="radio"/> Sept	6 6
<input type="radio"/> Oct	7 7
<input type="radio"/> Nov	8 8
<input type="radio"/> Dec	9 9

79. Have you ever used medication(s) for a mental health issue? Yes No

If YES, give date of most recent use of medication.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	0 0
<input type="radio"/> Apr	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4 4
<input type="radio"/> Aug	5 5
<input type="radio"/> Sept	6 6
<input type="radio"/> Oct	7 7
<input type="radio"/> Nov	8 8
<input type="radio"/> Dec	9 9

80. Have you ever received in-patient psychiatric care? Yes No

81. Have you ever tried to harm yourself or attempted suicide? Yes No

82. Have you ever been diagnosed with or treated for an eating disorder? Yes No

If YES, give date of your most recent treatment or support group participation.

Month	Year
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	0 0
<input type="radio"/> Apr	1 1
<input type="radio"/> May	2 2
<input type="radio"/> June	3 3
<input type="radio"/> July	4 4
<input type="radio"/> Aug	5 5
<input type="radio"/> Sept	6 6
<input type="radio"/> Oct	7 7
<input type="radio"/> Nov	8 8
<input type="radio"/> Dec	9 9

83. Do you have or have you had any other mental health condition not listed in Items 76–82? Yes No

84. Does walking 2 blocks on flat terrain cause you to experience shortness of breath, leg, joint, muscle or chest pain? Yes No

85. Does climbing 2 flights of stairs while carrying groceries or other items cause you to experience shortness of breath, leg, joint, muscle or chest pain? Yes No

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

PLEASE DO NOT WRITE IN THIS AREA



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86. Does kneeling, squatting or sitting cross-legged cause you leg, muscle or joint pain to the point that you cannot do these activities? Yes No
 Y N
87. Do you use a prosthesis or other assistive device, e.g., wheelchair, walker, cane, leg braces, hearing aid(s)? Yes No
 Y N
88. Do you have any deficit in your hearing, vision or speech that might affect your ability to learn a foreign language? Yes No
 Y N
89. Do you require assistance with routine activities such as walking, dressing, bathing, shopping or cooking? Yes No
 Y N
90. Does anything prohibit you from living and working in very hot, cold, humid or dry climates, or in polluted environments? (This refers to your ability to work and live in these environments, NOT your personal preferences.) Yes No
 Y N
91. Does anything prohibit you from living and working at high altitudes, such as above 5000 feet? Yes No
 Y N
92. Have you had treatment for periodontal disease which would require therapy (not just cleaning) more than once per year? Yes No
 Y N

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND ENTERED ALL DATES REQUIRED BEFORE GOING ON.

I certify that all of the above information is true and complete. I understand that giving false or incomplete information will delay processing my application and may result in withdrawal of my Peace Corps nomination or invitation or in separation from Peace Corps Service.

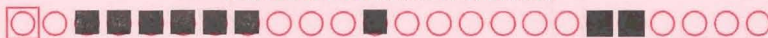
Printed Name _____

Date _____

Signature _____

DE Mark Reflex® forms by NCS Pearson EW-207740-6:6543 HR99 Printed in U.S.A.

PLEASE DO NOT WRITE IN THIS AREA



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