# Attachment 10a

# Adult Medical History Form

| Affix Case ID Label Here |
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# Survey of CFS and Chronic Unwellness in Georgia

## Medical History Form

Date: _____/_____/_____

Time: _____am/pm

1. If you have to list three **major** problems that you have with your health, what would they be? Please start with what bothers you the most.

| Problem/Complaint/Concern | When did this problem start? | Do you still have this health problem? |
|---|---|---|
| 1. | _____ /_____<br>MONTH YEAR | ☐ Yes<br>☐ No |
| 2. | _____ /_____<br>MONTH YEAR | ☐ Yes<br>☐ No |
| 3. | _____ /_____<br>MONTH YEAR | ☐ Yes<br>☐ No |

1a. From the time these problems began until now, how have they changed? If there is such a thing as a typical episode, please describe it. If you have no problems, go to question 2.

Problem 1.

Problem 2.

Problem 3.

## PAST MEDICAL HISTORY

2. **Before having the problems discussed above**, how would you describe your health? (Circle your answer).

Poor Fair Good Very Good Excellent

3. Before age 18, did you have any major **childhood health problems**? Please include problems that made you go to the doctor more often (not just for "check ups"), go to a hospital, or take medications. These problems include bad infections, reactions to immunizations or vaccinations, and other serious medical problems.

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 4**.

3a. Please describe these childhood health problems you had before age 18 and write below how old were you when you had the health problem. (If you don't remember your age, give your approximate age or think of political or historic events that were happening at that time to help you remember.) If problems or bad reactions to immunizations happened more than once, list them separately. If you need more space, use another sheet of paper.

| **Health problems before age 18** | **Age when problem occurred** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

4. The next question is about **medical problems** you have had **as an adult** (age 18 and over).

Have you had any medical problems for which you saw a doctor regularly? Please include bad infections, reactions to immunizations or vaccinations, and any other medical problems that bothered you.

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 5**

4a. Please describe your medical problems and the age at which you had them. If a medical problem or a bad reaction happened more than once, please list each occurrence separately. If you need more space, please use another sheet of paper.

| **Medical problems age 18 and after** | **Age when problem occurred** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

5. Have you ever had any serious injuries, such as head injury, broken bones, burns or others that required visiting your doctor, an emergency room, or being hospitalized?

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 6**

5a. Please describe your injuries and ages at which the injuries occurred. If you need more space, please use another sheet of paper.

| **Description of Injury** | **Age at which you were injured** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

6. Have you ever had other surgeries or hospitalizations? Please do not include the illnesses or injuries you described in items 4 and 5 above? (Women, please **do not** include hospitalizations for ***normal deliveries***)

☐ 1 Yes

☐ 2 No → **IF NO, GO TO QUESTION 7**

6a. Please describe your surgeries and hospitalizations. Please include the age at the time of the surgery or hospitalization. If you need more space, please use another sheet of paper.

| **Description of Surgery/Hospitalization** | **Age at Surgery/ Hospitalization** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

7. During a typical **7-day period** (a week), how many times, on average, do you do the following kinds of exercise for **more than 15 minutes during your leisure time**? Also, for how many minutes do you usually do each kind of exercise?

| | | **Times Per Week** | **Minutes Each Time** |
|---|---|---|---|
| 7a. | **STRENUOUS EXERCISE (HEART BEATS RAPIDLY)** (examples: running, jogging, soccer, squash, hockey, basketball, football, judo, roller skating, vigorous swimming, vigorous long distance bicycling) | | |
| 7b. | **MODERATE EXERCISE (NOT EXHAUSTING)** (examples: fast walking, lifting weights, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, popular and folk dancing, gardening) | | |
| 7c. | **MILD EXERCISE (MINIMAL EFFORT)** (examples: easy walking, yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling) | | |

7d. If you are you currently employed, what is the activity level of your job?

☐ 1 Not currently employed

☐ 2 Very active-one that involves heavy lifting, digging, strenuous labor (for example, construction labor, landscaping, lumberjack)

☐ 3 Active-one that involves walking and/or light lifting (for example, carpenter, mail delivery, janitor)

☐ 4 Moderately active-one that combines standing and walking (for example, security guard, mechanic, nursing)

☐ 5 Inactive-one that combines sitting and standing (for example, cashier, sales, teaching)

☐ 6 Very inactive-one that involves mostly sitting (for example, desk job, telemarketing, truck driver)

8. In the last year, did your weight change a lot?

☐ 1 Yes ☐ 2 No → **IF NO, GO TO QUESTION 9**

8a. Did you intend to gain or lose this weight?

☐ 1 Yes ☐ 2 No

8b. How much weight did you gain in the last year? _____ pounds

8c. How much weight did you lose in the last year? _____ pounds

**TOBACCO USE**

9. Have you ever smoked **cigarettes** regularly, that is, as least one per day for six months or longer?

☐ 1 Yes ☐ 2 No → **IF NO, GO TO QUESTION 10**

9a. **How old** were you when you started smoking cigarettes regularly? Age: _____

9b. How many cigarettes would you say you smoke(d) per day?

Cigarettes per day: _____

9c. Do you currently smoke cigarettes?

☐ 1 Yes → **IF YES, GO TO QUESTION 9e** ☐ 2 No

9d. How old were you when you quit smoking cigarettes? Age: _____

9e. Between the time when you started smoking cigarettes and the time that you quit or now, was there ever a period of one year or longer when you did not smoke cigarettes?

☐ 1 Yes ☐ 2 No → **IF NO, GO TO QUESTION 10**

9f. How many years did you not smoke cigarettes?

Number of years: _____

10. Do you currently smoke cigars?

☐ 1 Yes ☐ 2 No

11. Do you currently chew tobacco?

☐ 1 Yes ☐ 2 No

12. Do you currently use snuff?

☐ 1 Yes ☐ 2 No

**The rest of this questionnaire is about health history. For some conditions or health problems you have had, please tell us the age at which it began and whether you have had this condition or illness in the past 12 months. The clinic doctor and nurse will review your completed form with you during your clinic appointment.**

| **Have you ever had this condition or illness?** | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | **DOCTOR/NURSE USE ONLY** |
|---|---|---|---|---|
| 13a. Asthma | ☐ Yes<br>☐ No (SKIP TO 13B) | AGE: ____ | ☐ Yes<br>☐ No | Ask about the allergens. |
| 13b. Sudden, severe swelling of the face, mouth, and throat (Quincke's edema) | ☐ Yes<br>☐ No (SKIP TO 13C) | AGE: ____ | ☐ Yes<br>☐ No | Ask about the allergens. |
| 13c. Anaphylactic shock | ☐ Yes<br>☐ No (SKIP TO 13D) | AGE: ____ | ☐ Yes<br>☐ No | Ask about the allergens. |
| 13d. Other allergies | ☐ Yes<br>☐ No (SKIP TO 14a) | AGE: ____ | ☐ Yes<br>☐ No | Ask about the allergens |
| 13e. What other allergies have you had? | | | | Ask about the allergens. |
| **Skin** | | | | |
| 14a. Eczema | ☐ Yes<br>☐ No (SKIP TO 14B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 14b. Hives | ☐ Yes<br>☐ No (SKIP TO 14C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 14c. Skin rashes | ☐ Yes<br>☐ No (SKIP TO 14D) | AGE: ____ | ☐ Yes<br>☐ No | |
| 14d. Skin discoloration or swelling | ☐ Yes<br>☐ No (SKIP TO 14E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 14e. Other skin problems | ☐ Yes<br>☐ No (SKIP TO 15A) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 14f. What other skin problems have you had? | | | | |
| **Head** | | | | |
| 15a. **Headaches** (for example, tension headaches, migraines) | ☐ Yes<br>☐ No (SKIP TO 16A) | AGE: ____ | ☐ Yes<br>☐ No | |
| **Eyes** | | | | |
| 16a. Glaucoma | ☐ Yes<br>☐ No (SKIP TO 16B) | AGE: ____ | | |
| 16b. Eye infection | ☐ Yes<br>☐ No (SKIP TO 16C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 16c. Cataract | ☐ Yes<br>☐ No (SKIP TO 16D) | AGE: ____ | | |
| 16d. Other eye problems | ☐ Yes<br>☐ No (SKIP TO 17A) | AGE: ____ | ☐ Yes<br>☐ No | |
| 16e. What other eye problems have you had? | | | | |
| **Ears, Nose, Mouth and Throat** | | | | |
| 17a. Problems hearing | ☐ Yes<br>☐ No (SKIP TO 17B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 17b. Ringing in your ears | ☐ Yes<br>☐ No (SKIP TO 17C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 17c. Ear infections as an adult | ☐ Yes<br>☐ No (SKIP TO 17D) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 17d. Problems with a stuffy nose or drainage from your nose to your throat. | ☐ Yes<br>☐ No (SKIP TO 17E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 17e. Sores in your mouth or nose | ☐ Yes<br>☐ No (SKIP TO 17F) | AGE: ____ | ☐ Yes<br>☐ No | |
| 17f. Problems with dry mouth | ☐ Yes<br>☐ No (SKIP TO 17G) | AGE: ____ | ☐ Yes<br>☐ No | |
| 17g. Gum disease (for example: bleeding gums, gum recession) | ☐ Yes<br>☐ No (SKIP TO 17H) | AGE: ____ | ☐ Yes<br>☐ No | |
| 17h. Problems swallowing or the feeling of a lump in your throat | ☐ Yes<br>☐ No (SKIP TO 18A) | AGE: ____ | ☐ Yes<br>☐ No | |
| **Neck** | | | | |
| 18a. Tenderness or pain in your neck | ☐ Yes<br>☐ No (SKIP TO 19A) | AGE: ____ | ☐ Yes<br>☐ No | |
| **Digestive System** | | | | |
| 19a. Poor appetite | ☐ Yes<br>☐ No (SKIP TO 19B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19b. Excessive appetite | ☐ Yes<br>☐ No (SKIP TO 19C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19c. Heartburn or gastro-esophageal reflux (GER) | ☐ Yes<br>☐ No (SKIP TO 19D) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19d. Gastritis or ulcer | ☐ Yes<br>☐ No (SKIP TO 19E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19e. Blood in bowel movements | ☐ Yes<br>☐ No (SKIP TO 19F) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 19f. Hemorrhoids | ☐ Yes<br>☐ No (SKIP TO 19G) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19g. Inflammatory bowel disease, ulcerative colitis or Crohn's disease | ☐ Yes<br>☐ No (SKIP TO 19H) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19h. Hepatitis | ☐ Yes<br>☐ No (SKIP TO 19I) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19i. Cirrhosis | ☐ Yes<br>☐ No (SKIP TO 19J) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19j. Gallbladder problems | ☐ Yes<br>☐ No (SKIP TO 19K) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19k. Recurring or persistent nausea or vomiting | ☐ Yes<br>☐ No (SKIP TO 19L) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19l. Recurring or persistent diarrhea | ☐ Yes<br>☐ No (SKIP TO 19M) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19m. Recurring or persistent constipation | ☐ Yes<br>☐ No (SKIP TO 19N) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19n. Chronic or persistent bloating | ☐ Yes<br>☐ No (SKIP TO 19O) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19o. Other problems with digestive system | ☐ Yes<br>☐ No (SKIP TO 19Q) | AGE: ____ | ☐ Yes<br>☐ No | |
| 19p. What other problems have you had with your digestive system? | | | | |
| 19q. High cholesterol | ☐ Yes<br>☐ No (SKIP TO 19R) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 19r. High triglycerides | ☐ Yes<br>☐ No (SKIP TO 20A) | AGE: ____ | ☐ Yes<br>☐ No | |
| **Chest: Heart and Lungs** | | | | |
| 20a. Chronic cough | ☐ Yes<br>☐ No (SKIP TO 20B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20b. Chronic bronchitis | ☐ Yes<br>☐ No (SKIP TO 20C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20c. Chronic obstructive pulmonary disease (COPD) or emphysema | ☐ Yes<br>☐ No (SKIP TO 20D) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20d. Shortness of breath when inactive (sitting or in bed) | ☐ Yes<br>☐ No (SKIP TO 20E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20e. Shortness of breath when you walk, run, or climb stairs | ☐ Yes<br>☐ No (SKIP TO 20F) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20f. Fluid in your lungs | ☐ Yes<br>☐ No (SKIP TO 20G) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20g. Pneumonia | ☐ Yes<br>☐ No (SKIP TO 20H) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20h. Wheezing | ☐ Yes<br>☐ No (SKIP TO 20I) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20i. Chest pain | ☐ Yes<br>☐ No (SKIP TO 20J) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20j. **High** blood pressure | ☐ Yes<br>☐ No (SKIP TO 20K) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20k. **Low** blood pressure | ☐ Yes<br>☐ No (SKIP TO 20L) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 20l. Heart problems or irregular heart beat (arrhythmia) | ☐ Yes<br>☐ No (SKIP TO 20M) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20m. Problems with your arteries | ☐ Yes<br>☐ No (SKIP TO 20N) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20n. Swelling of your legs | ☐ Yes<br>☐ No (SKIP TO 20O) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20o. Feet or hands get cold very easily | ☐ Yes<br>☐ No (SKIP TO 20P) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20p. Other lung,heart or vascular problems? | ☐ Yes<br>☐ No (SKIP TO 21A) | AGE: ____ | ☐ Yes<br>☐ No | |
| 20q. What other lung, heart or vascular problems have you had? | | | | |
| **Urinary Tract** | | | | |
| 21a. Bladder or kidney infection, or urinary tract infection (UTI) | ☐ Yes<br>☐ No (SKIP TO 21B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 21b. Kidney stones | ☐ Yes<br>☐ No (SKIP TO 21C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 21c. Frequent need to urinate (pee) | ☐ Yes<br>☐ No (SKIP TO 21D) | AGE: ____ | ☐ Yes<br>☐ No | |
| 21d. Problems with starting to urinate (pee) | ☐ Yes<br>☐ No (SKIP TO 21E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 21e. Burning sensation or pain when urinating (peeing) | ☐ Yes<br>☐ No (SKIP TO 21F) | AGE: ____ | ☐ Yes<br>☐ No | |
| 21f. Other kidney or urinary problems | ☐ Yes<br>☐ No (SKIP TO 21H) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 21g. What other kidney or urinary problems have you had? | | | | |
| 21h. How many times per night, on average, do you get up to go to the bathroom?<br>___ times | | | | |
| **Nervous System** | | | | |
| 22a. Dizziness or vertigo ("head spinning") | ☐ Yes<br>☐ No (SKIP TO 22B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22b. Feeling faint or fainting | ☐ Yes<br>☐ No (SKIP TO 22C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22c. Poor balance | ☐ Yes<br>☐ No (SKIP TO 22D) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22d. Poor coordination | ☐ Yes<br>☐ No (SKIP TO 22E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22e. Numbness or tingling on face, trunk, arms or legs | ☐ Yes<br>☐ No (SKIP TO 22F) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22f. Loss of consciousness (other than fainting) | ☐ Yes<br>☐ No (SKIP TO 22G) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22g. Seizures | ☐ Yes<br>☐ No (SKIP TO 22H) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22h. Encephalitis | ☐ Yes<br>☐ No (SKIP TO 22I) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22i. Meningitis | ☐ Yes<br>☐ No (SKIP TO 22J) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 22j. Other neurological problems | ☐ Yes<br>☐ No (SKIP TO 23A) | AGE: ____ | ☐ Yes<br>☐ No | |
| 22k. What other neurological problems have you had? | | | | |
| **Musculo-skeletal System** | | | | |
| 23a. Pain in muscles, tendons or joints | ☐ Yes<br>☐ No (SKIP TO 23B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23b. Stiffness in joints or back | ☐ Yes<br>☐ No (SKIP TO 23C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23c. Carpal tunnel syndrome or other tendon problems | ☐ Yes<br>☐ No (SKIP TO 23D) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23d. Bone problems (including osteopenia and osteoporosis) | ☐ Yes<br>☐ No (SKIP TO 23E) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23e. Muscle weakness | ☐ Yes<br>☐ No (SKIP TO 23F) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23f. Systemic Lupus Erythematosus | ☐ Yes<br>☐ No (SKIP TO 23G) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23g. Rheumatoid Arthritis | ☐ Yes<br>☐ No (SKIP TO 23H) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23h. Other arthritis | ☐ Yes<br>☐ No (SKIP TO 23J) | AGE: ____ | ☐ Yes<br>☐ No | |
| 23i. What other arthritis have you had? | | | | |
| 23j. Fibromyalgia | ☐ Yes<br>☐ No (SKIP TO 24A) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| **Endocrine System** | | | | |
| 24a. Diabetes or high blood sugar | ☐ Yes<br>☐ No (SKIP TO 24B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 24b. Problems with your thyroid gland | ☐ Yes<br>☐ No (SKIP TO 24C) | AGE: ____ | ☐ Yes<br>☐ No | |
| 24c. Other endocrine problems | ☐ Yes<br>☐ No (SKIP TO 25A) | AGE: ____ | ☐ Yes<br>☐ No | |
| 24d. What other endocrine problems have you had? | | | | |
| **Blood** | | | | |
| 25a. Anemia, low hemoglobin, "thin blood," or low number of red blood cells | ☐ Yes<br>☐ No (SKIP TO 25B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 25b. Easy bruising or bleeding | ☐ Yes<br>☐ No (SKIP TO 25C) | AGE: ___ | ☐ Yes<br>☐ No | |
| 25c. Very **low** white blood cell count | ☐ Yes<br>☐ No (SKIP TO 25D) | AGE: ___ | ☐ Yes<br>☐ No | |
| 25d. Very **high** white blood cell count | ☐ Yes<br>☐ No (SKIP TO 25E) | AGE: ___ | ☐ Yes<br>☐ No | |
| 25e. Leukemia | ☐ Yes<br>☐ No (SKIP TO 25F) | AGE: ____ | ☐ Yes<br>☐ No | |
| 25f. Hodgkin's Lymphoma | ☐ Yes<br>☐ No (SKIP TO 25G) | AGE: ____ | ☐ Yes<br>☐ No | |
| 25g. Lymphoma (non-Hodgkin's) | ☐ Yes<br>☐ No (SKIP TO 25H) | AGE: ____ | ☐ Yes<br>☐ No | |

| Have you ever had this condition or illness? | | If "YES": How old were you when you first had this condition? | If "YES": Have you had this condition in the last 12 months? | DOCTOR/NURSE USE ONLY |
|---|---|---|---|---|
| 25h. Swollen lymph nodes (for example, around your neck, or in your groin, or armpits or other places on your body) | ☐ Yes<br>☐ No (SKIP TO 25I) | AGE: ____ | ☐ Yes<br>☐ No | |
| 25i. Infectious mono-nucleosis (also called "Mono") | ☐ Yes<br>☐ No (SKIP TO 25J) | AGE: ____ | ☐ Yes<br>☐ No | |
| 25j. Blood diseases (such as sickle cell anemia, thalassemia or hemophilia) | ☐ Yes<br>☐ No (SKIP TO 25L) | AGE: ____ | ☐ Yes<br>☐ No | |
| 25k. What blood diseases have you had? (Check all that apply.)<br>☐ Sickle cell anemia<br>☐ Thalassemia<br>☐ Hemophilia<br>☐ Other, please specify: _____<br>_____ Age started: _____ | | | | |
| 25l. Have you ever had blood transfusions? | ☐ Yes<br>☐ No (SKIP TO 26A) | AGE: ____ | | For what reason |
| **Sexual History** | | | | |
| 26a. Low sexual drive/desire | ☐ Yes<br>☐ No (SKIP TO 26B) | AGE: ____ | ☐ Yes<br>☐ No | |
| 26b. Pain during sexual intercourse | ☐ Yes<br>☐ No (SKIP TO 27A) | AGE: ____ | ☐ Yes<br>☐ No | |
| **FEMALES, PLEASE SKIP TO 27a. Also, remember to fill out the gynecological questionnaire.** | | | | |
| 27a. Problems with prostate (**MALES ONLY)** | ☐ Yes<br>☐ No (SKIP TO 28A) | AGE: ____ | ☐ Yes<br>☐ No | |

28a. Are there any other particular problems or concerns related to your health that you would like to mention?

☐ 1 Yes → **GO TO QUESTION 28B**

☐ 2 No → **GO TO NEXT PAGE**

28b. Please describe the problems or concerns below. Use more pages if necessary.

| **Other diseases (or health problems/ concerns)** | How old were you when this problem began? | Do you still have this problem? | **DOCTOR/NURSE USE ONLY** |
|---|---|---|---|
| 1. | AGE: _____ | ☐ Yes<br>☐ No | |
| 2. | AGE: _____ | ☐ Yes<br>☐ No | |
| 3. | AGE: _____ | ☐ Yes<br>☐ No | |
| 4. | AGE: _____ | ☐ Yes<br>☐ No | |
| 5. | AGE: _____ | ☐ Yes<br>☐ No | |
| 6. | AGE: _____ | ☐ Yes<br>☐ No | |

## Additional notes to questions

If you wish to explain more about a condition or illness that you had, please use the space provided below (Remember to enter the number of the question to which your explanation applies).

**Thank You!**
**Please bring this form with you to your clinic appointment.**