

Peace Corps Health Outcomes

Introduction

Peace Corps has partnered with the Centers for Disease Control and Prevention to determine the health of returned Peace Corps Volunteers. The investigators have developed an online survey for returned Peace Corps Volunteers to complete.

Burden Statement: Public reporting burden for this collection of information is estimated to average 25 minutes per response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to pcfr@peacecorps.gov , Subject line: PRA (0420-####). Do not return the completed form to this email address.

OMB Control No. 0420-xxxx

Expiration Date: x/xx/20xx

Purpose and Consent

Introduction and purpose

The Centers for Disease Control and Prevention (CDC) and Peace Corps are conducting a survey to learn about the health of Peace Corps Volunteers (PCVs). This survey will help us understand what diseases for which PCVs might be at risk. To do this, we are conducting anonymous surveys among PCVs who served between 1995–2014. We would like to invite you to take part in this survey.

Procedures

Taking this survey is up to you. Participating will not cost you anything. If you agree, we will ask you some questions about your health since leaving Peace Corps. You can choose not to answer any questions that you wish for any reasons. The survey will take an average of 25 minutes to complete. Once completed, the survey results will be sent to CDC.

Confidentiality

Survey results will be compiled and analyzed as a group. Although aggregate results will be shared with Peace Corps, no information that can identify you individually will be collected or shared. Survey data will be kept private to the extent allowed by law.

Risks/benefits

This survey has little risk. The information we collect could benefit PCVs by improving the knowledge of PCMOs on the health risks of PCVs.

Cost

The only cost to you for being in the survey is your time. You will not be paid to take part in this survey.

Right to refuse or withdraw

It is up to you to join the assessment or to withdraw at any time. You can choose to skip any questions you do not want to answer. While taking the survey, if you decide that you do not want to take part, you can simply stop answering questions.

Persons to contact

If, at any time, you have questions or problems related to this assessment, you may contact Kathrine Tan (404) 718-4701 ,
e-mail: ktan@cdc.gov

* I have read the above information and:

- I consent to participate
- I do NOT consent to participate

Section 1: Peace Corps - Service

The following questions are about your time as a Peace Corps Volunteer.

* In what country did you serve as a Peace Corps Volunteer? If you served in more than one country, please list the country that you served in first.

Other (please specify)

What best describes the location of your assignment?

- Rural (Less than 1,000 people per square mile. Ex: village or town with dirt roads)
- Urban (1,000 or more people per square mile. Ex: capital city of the country)

* When did you start (includes pre-service training) and finish (includes close of service, early termination, medical separation, or evacuation) your Peace Corps Service in country?

	Month	Year
Start	<input type="text"/>	<input type="text"/>
Finish	<input type="text"/>	<input type="text"/>

What was your primary work assignment as a Peace Corps Volunteer?

- Education
- Agriculture
- Community economic development
- Youth in development
- Environment
- Health
- Other (please specify)

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Section 1: Peace Corps - Cookfires

While in Peace Corps, were you exposed to smoke from cookfires, either from wood or charcoal? (i.e. used fire for cooking, or visited or lived in a house where cookfires were used)

Yes

No

Don't know

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Section 1: Peace Corps Volunteer - Cookfire exposure

Where were you exposed (check all that apply)?

- Indoors
- Outdoors
- Both indoors and outdoors

How often were you exposed?

- Daily
- Some days of the week
- Rarely
- Never
- Don't know

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Section 1: Peace Corps - Water Safety

While in Peace Corps, what were the two main water safety measures, if any, did you take? (can select up to two)

- Bleach or chlorine
- Aquatabs
- Boiled water
- Filtered water using a Peace Corps approved filter
- Iodine tablets
- None
- Not applicable
- Don't know
- Other (please specify)

Section 1: Peace Corps - Mosquito Avoidance Measures

What statement best describes your use of mosquito repellent during Peace Corps?

- I used a DEET-containing mosquito repellent every day.
- I used some type of mosquito repellent every day.
- I used a DEET-containing mosquito repellent most days.
- I used some type of mosquito repellent most days.
- I used a DEET-containing mosquito repellent some days.
- I used some type of mosquito repellent some days.
- I never used a mosquito repellent.
- Don't know

What statement best describes your use of mosquito nets?

- I used a mosquito net every night
- I used a mosquito net most nights
- I used a mosquito net some nights
- I used a mosquito net rarely
- Don't know

Section 2: Malaria Prevention During Peace Corps

* While in Peace Corps, were you prescribed a medication to prevent malaria?

- Yes
- No
- Don't know

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Section 2: Malaria Prevention During Peace Corps - Antimalarials

What was the first antimalarial you took during your Peace Corps service?

- Atovaquone/proguanil (malarone)
- Chloroquine or Plaquenil
- Doxycycline
- Mefloquine (Lariam)
- Other (please specify)

What statement best describes how you took the medication while in Peace Corps:

- I took the medication as prescribed.
- I took the medication as prescribed most of the time.
- I took the medication about half of the time.
- I rarely took the medication (less than half of the time).
- I never took the medication.
- I stopped taking the medication and switched to another because of side effects.
- I don't know.
- Other (please specify)

Approximate length of time actually taking the medication (in months):

Last time this particular medication for malaria prophylaxis was taken during Peace Corps (if you completed a trip directly after close of service in an area which required malaria prophylaxis, note the last time it was taken for this trip)

Date	Month	Year
	<input type="text"/>	<input type="text"/>

Were you prescribed any other medication for malaria prophylaxis during Peace Corps?

- Yes
- No
- Don't know

Section 2: Malaria Prevention During Peace Corps - Other Antimalarials

Why was a different medication prescribed?

- Side effects from original antimalarial
- Deployment to a different area requiring a different antimalarial
- Other (please specify)

What antimalarial were you prescribed?

- Atovaquone/proguanil (malarone)
- Chloroquine
- Doxycycline
- Mefloquine (Lariam)
- Other (please specify)

What statement best describes how you took the medication while in Peace Corps:

- I took the medication as prescribed.
- I took the medication as prescribed most of the time.
- I took the medication about half of the time.
- I rarely took the medication (less than half of the time).
- I never took the medication.
- I don't know.
- Other (please specify)

Approximate length of time actually taking the medication (in months):

Last time this particular medication for malaria prophylaxis was taken during Peace Corps (if you traveled right after close of service in an area which required malaria prophylaxis, and you continued to take this same medication note the last time it was taken for this trip).

	Month	Year
Date	<input type="text"/>	<input type="text"/>

Section 2: After Peace Corps - Other Malaria Preventive Medications

Have you taken medication for malaria prophylaxis since leaving Peace Corps?

- Yes
- No
- Don't know

Section 2: After Peace Corps - Other Malaria Preventive Medications

Since leaving Peace Corps, have you taken more than 6 months worth of malaria prophylaxis at a time?

- Yes
- No
- Don't know

Section 3: Health Questions

The next few questions will help us understand your health prior, during, and after Peace Corps.

Section 3: Health Questions - Skin Conditions

* Have you ever been diagnosed by a health care provider with skin conditions such as:

Acne

Allergic dermatitis (allergic rash)

Contact dermatitis (rash from contact with something)

Fungal infection of skin ("ring worm")

Psoriasis

Skin cancer

Yes

No

Don't know

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Section 3: Health Questions - Skin Conditions - Diagnoses

* Please indicate if you have had any of the following skin conditions. For any conditions that you have NOT had, please indicate "never diagnosed". For any condition that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic dermatitis (allergic rash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact dermatitis (rash from contact with something)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungal infection of skin (also called "ring worm")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other skin condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions - Skin Conditions - Medications Y/N

Have you ever taken medication for your skin condition(s)?

- Yes
- No
- Don't know

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Section 3: Health Questions - Skin Conditions - Medications

Please select any medications taken for your skin condition(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Adalimumab (Humira)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anthralin (Zithranol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcipotriene (Dovonex, Sorilux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doxycycline (Vibramycin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocortisone cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isotretinoin (Accutane, Sotret)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Rheumatrex, Trexall)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions - Heart Conditions

* Have you ever been diagnosed by a health care provider with heart or circulation problems?

For example:

Arrhythmia (irregular heartbeat)

Cardiomyopathy

Congestive heart failure

High cholesterol

Hypertension (high blood pressure)

Myocardial infarction (heart attack)

Yes

No

Don't know

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Section 3: Health Questions - Heart Conditions - Diagnoses

* Please indicate if you have had the following heart or circulatory conditions. For any condition that you have NOT had, please indicate "never diagnosed". For any condition that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Arrhythmia (irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction (heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other heart condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Heart Conditions – Medications Y/N

Have you ever taken medication for your heart or circulatory condition(s)?

- Yes
- No
- Don't know

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Section 3: Health Questions - Heart Conditions - Medications

Please select any medications taken for your heart condition(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atenolol (Tenormin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atorvastatin (Lipitor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Captopril (Capoten)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluvastatin (Lescol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Furosemide (Lasix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrochlorothiazide (Aquazide H, HydroDIURIL, Microzide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lisinopril (Prinvil, Zestril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losartan (Cozaar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovastatin (Altacor, Altoprev, Mevacor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metoprolol (Lopressor, Toprol-XL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pravastatin (Pravachol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosuvastatin (Crestor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simvastatin (Zocor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warfarin (Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions - Lung Conditions

* Have you ever been diagnosed by a health care provider with lung problems?

For example:

Asthma

Chronic obstructive pulmonary disease (COPD), bronchitis or emphysema

Lung cancer

Recurrent pneumonia

Restrictive lung disease

Yes

No

Don't know

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Section 3: Health Questions - Lung Conditions - Diagnoses

* Please indicate if you have had the following lung conditions. For any lung condition that you have NOT had, please indicate "never diagnosed". For any lung condition that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic obstructive pulmonary disease (COPD), chronic bronchitis, or emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restrictive lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other lung condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions –Lung Conditions – Medications Y/N

* Have you ever taken medication for your lung condition(s)?

- Yes
- No
- Don't know

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Section 3: Health Questions - Lung Conditions - Medications

Please select any medications taken for your lung condition(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Albuterol (Accuneb, ProAir, Proventil, Ventolin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albuterol-ipratropium bromide (Combivent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluticasone (Fluticasone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metaproteranol (Alupent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mometasone (Asmanex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Montelukast (Singulair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prednisone (Rayos, Sterapred)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prednisolone (Orapred, Prelone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Triamcinolone (Azmacort)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions - Gastrointestinal/stomach problems

* Have you ever been diagnosed by a health care provider with gastrointestinal or stomach problems?

For example:

Amoebas

Crohn's disease

Cirrhosis

Duodenal ulcers

Esophageal ulcers

Fatty liver

Gastroesophageal reflux (GERD) or heartburn

Giardia

Inflammatory bowel disease

Irritable bowel syndrome (IBS)

Liver failure

Peptic Ulcers

Yes

No

Don't know

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Section 3: Health Questions – Gastrointestinal/stomach problems – Diagnoses

* Please indicate if you have had the following gastrointestinal/stomach problems. For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Amoebas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal reflux (GERD) or heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giardia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other gastrointestinal/stomach disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Gastrointestinal/stomach problems – Medications Y/N

Have you ever taken medication for your gastrointestinal/stomach problems?

- Yes
- No
- Don't know

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Section 3: Health Questions – Gastrointestinal/stomach problems – Medications

Please select any medications taken for your gastrointestinal/stomach problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Balsalazide (Colazal , Giazo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Certolizumab (Cimzia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cimetidine (Tagamet , Tagamet HB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin (Cipro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dexamethasone (Baycadron , Dexpak , Zema Pak)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esomeprazole (Nexium)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Famotidine (Pepcid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infliximab (Remicade)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lansoprazole (Prevacid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maalox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mesalamine (Apriso , Asacol , Delzicol , Lialda)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methylprednisolone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metronidazole (Flagyl)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mylanta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natalizumab (Tysabri)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Omeprazole (Prilosec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pantoprazole (Protonix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prednisolone (Orapred , Prelone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prednisone (Rayos , Sterapred)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Ranitidine (Taladine, Zantac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfasalazine (Azulfidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Genital, reproductive, or urinary tract problems

* Have you ever been diagnosed by a health care provider with genital, reproductive, or urinary tract (kidney/bladder) problems?

For example:

Kidney stones

Miscarriages

Recurrent urinary tract infections

Recurrent vaginal yeast infections

Yes

No

Don't know

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Section 3: Health Questions – Genital, reproductive, or urinary tract problems – Diagnoses

* Please indicate if you have had the following genital, reproductive, urinary tract problems. For any problems that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent urinary tract infections (3 or more episodes in 1 year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent vaginal yeast (4 or more episodes in 1 year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other genital, reproductive, or urinary tract problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Genital, reproductive, urinary tract problems – Medications Y/N

* Have you ever taken medication for your genital, reproductive, or urinary tract problems?

Yes

No

Don't know

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Section 3: Health Questions - Genital, reproductive, or urinary tract problems - Medications

Please select any medications taken for your genital, reproductive, or urinary tract problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Amoxicillin-clavulanate (Augmentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin (Cipro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluconazole (Diflucan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin (Levaquin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miconazole (Monistat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitrofurantoin (Macrobid, Macrochantin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfamethoxazole- trimethoprim (Bactrim, Septra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Immunologic, rheumatologic, or oncologic problems

* Have you ever been diagnosed by a health care provider with immunologic, rheumatologic, or oncologic (cancer) problems?

For example:

Breast cancer

Gastric cancer

Leukemia

Liver cancer

Lymphoma

Prostate cancer

Rheumatoid arthritis

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Immunologic, rheumatologic, or oncologic problems - Diagnoses

* Please indicate if you have had the following immunologic, rheumatologic, or oncologic problems. For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other immunologic, rheumatologic, or oncologic problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Immunologic, rheumatologic, or oncologic problem - Medications
Y/N

Have you ever taken medication for your immunologic, rheumatologic, or oncologic problems?

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions - Immunologic, rheumatologic, or oncologic problems - Medications

Please select any medications taken for your immunologic, rheumatologic, or oncologic problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Chemotherapy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dexamethasone (Baycadron, DexPak, Zema Pak)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydroxychloroquine (Plaquenil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil, Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin (Levaquin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Trexall)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naproxen (Aleve, Naprosyn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prednisolone (Millipred, Orapred, Prelone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prednisone (Rayos, Sterapred)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfasalazine (Azulfidine, Sulfazine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Infectious diseases

* Have you ever been diagnosed by a health care provider with infectious diseases?

For example:

Amoebas

Antibiotic resistant infections

Chikungunya

Dengue

Eye infection

Gastrointestinal infection

Giardia

Leishmaniasis

Malaria

Pneumonia

Positive PPD (skin test for tuberculosis)

Schistosomiasis

Skin infections

Sexually transmitted disease

Tuberculosis (active)

Urinary tract infection (kidney, bladder)

Vaginal yeast infection

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Infectious diseases - Diagnoses

* Please indicate if you have had the following infectious diseases. For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Amoebas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotic resistant infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chikungunya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dengue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal infection (not listed here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giardia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive PPD (skin test for tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schistosomiasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections (kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal yeast infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Infectious disease - Medication Y/N

* Have you ever taken medication for your infectious disease(s)?

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions - Infectious diseases - Medications

Please select any medications taken for your infectious disease(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Amoxicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amoxicillin-clavulanate (Augmentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artemether-lumefantrine (Coartem)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atovaquone-proguanil (Malarone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azithromycin (Zithromax, Zmax)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cefpodoxime (Vantin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cefuroxime (Ceftin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cephalexin (Keflex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chloroquine (Aralen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin (Cipro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin (Cleocin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doxycycline (Vibramycin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol (Myambutol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluconazole (Diflucan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gatifloxacin (Tequin, Teqpaq)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydroxychloroquine (Plaquenil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isoniazid (Nydrazid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin (Levaquin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mefloquine (Lariam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metronidazole (Flagyl)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Miconazole (Monistat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primaquine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quinine (Qulaquin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifampin (Rifadin, Rimactane)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfamethoxazole-trimethoprim (Bactrim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline (Ala-Tet, Panmycin, Sumycin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Metabolic, endocrine, or hormonal problems

* Have you ever been diagnosed by a health care provider with metabolic, endocrine, or hormonal problems other than menopause?

For example:

Diabetes

Hyperlipidemia (high cholesterol)

Hyperthyroidism

Hypothyroidism

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Metabolic, endocrine, or hormonal problems - Diagnoses

* Please indicate if you have had the following metabolic, endocrine, or hormonal problems. For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia (high cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other metabolic or hormonal problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Metabolic, endocrine, or hormonal problems - Medication Y/N

Have you ever taken medication for your metabolic, endocrine, or hormonal problem(s)?

Yes

No

Don't know

Section 3: Health Questions - Metabolic, endocrine, or hormonal problems - Medications

Please select any medications taken for your metabolic, endocrine, or hormonal problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Alogliptin (Nesina)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atorvastatin (Lipitor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerivastatin (Baycol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluvastatin (Lescol, Lescol XL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glimepiride (Amaryl)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glipizide (Glucotrol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glyburide (Diabeta, Glynase, Micronase)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin (any type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linagliptin (Tradjenta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovastatin (Altacor, Altoprev)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metformin (Glucophage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nateglinide (Starlix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pioglitazone (Actos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pravastatin (Lipostat, Pravachol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaglinide (Prandin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosiglitazone (Avandia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosuvastatin (Crestor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simvastatin (Zocor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitagliptin (Januvia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Troglitazone (Rezulin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Musculoskeletal problems

* Have you ever been diagnosed by a health care provider with musculoskeletal problems?

For example:

Fracture

Osteoporosis

Tendon rupture

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Musculoskeletal problems - Diagnoses

* Please indicate if you have had the following musculoskeletal problems For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Fracture (specify location below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendon rupture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other musculoskeletal problem (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "fracture" or "other" please specify

Section 3: Health Questions – Musculoskeletal problems - Medication Y/N

Have you ever taken medication for your musculoskeletal problem(s)?

- Yes
- No
- Don't know

Peace Corps Health Outcomes

Section 3: Health Questions - Musculoskeletal problems - Medications

Please select any medications taken for your musculoskeletal problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alendronate (Fosamax)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibandronate (Boniva , Bondronat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil , Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naproxen (Aleve , Naprosyn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raloxifene (Evista)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risendronate (Actonel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Neurologic problems

* Have you ever been diagnosed by a health care provider with neurologic problems?

For example:

Cluster headache

Dementia

Hearing loss

Insomnia

Migraines

Neuropathy

Seizures

Tension headache

Tinnitus

Vestibular disorder (vertigo)

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Neurologic Problems - Diagnoses

* Please indicate if you have had the following neurologic problems. For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Cluster headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vestibular disorder (vertigo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other neurologic problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Neurologic problems - Medication Y/N

* Have you ever taken medication for your neurologic problem(s)?

- Yes
- No
- Don't know

Peace Corps Health Outcomes

Section 3: Health Questions - Neurologic problems - Medications

Please select any medications taken for your neurologic problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amoxapine (Asendin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amitriptyline (Vanatrip, Elavil, Endep)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbamazepine (Carbatrol, Epitol, Equetro, Tegretol, Tegretol XR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clomipramine (Anafranil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Desipramine (Norpramin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dimenhydrinate (Dramamine, Driminate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphenhydramine (Benadryl, Diphen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Divalproex sodium (Depakote, Depakote ER)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doxepin (Silenor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eslicarbazepine (Aptiom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gabapentin (Neurontin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Aleve, Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imipramine (Tofranil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meclizine (Antivert, Bonine, Dramamine Less Drowsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naproxen (Aleve, Naprosyn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Nortriptyline (Aventyl , Pamelor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxcarbazepine (Oxtellar XR , Trileptal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phenytoin (Dilantin , Phenytek)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregabalin (Lyrica)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rizatriptan (Maxalt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sumatriptan (Imitrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiagabine (Gabitril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vigabatrin (Sabril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Ophthalmologic (eye) Problems

Do you currently wear glasses or contacts?

- Yes
- No
- Don't know

* Have you ever been diagnosed by a health care provider with ophthalmologic (eye) problems?

For example

Cataracts

Corneal ulcer

Glaucoma

Keratitis

Macular degeneration

Retinopathy

- Yes
- No
- Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Ophthalmologic (eye) problems - Diagnoses

* Please indicate if you have had the following ophthalmologic (eye) problems For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keratitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ophthalmologic problem (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Ophthalmologic problems - Medication Y/N

Have you ever taken medication for your ophthalmologic problem(s)?

- Yes
- No
- Don't know

Peace Corps Health Outcomes

Section 3: Health Questions - Ophthalmologic problems - Medications

Please select any medications taken for your ophthalmologic problem(s), and if applicable indicate when taken. Select all that apply. *Note that generic names are listed in alphabetical order with the brand name in bold.*

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Betaxolol ophthalmic (Betoptic, Betoptic S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latanoprost ophthalmic (Xalatan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ranibizumab ophthalmic (Lucentis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timolol ophthalmic (Betimol, Istalol, Timoptic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Psychiatric problems

* Have you ever been diagnosed by a health care provider with psychiatric problems?

For example:

Anxiety disorder

Bipolar disorder

Depression

Obsessive-compulsive disorder

Schizophrenia

Yes

No

Don't know

Peace Corps Health Outcomes

Section 3: Health Questions – Psychiatric problems - Diagnoses

* Please indicate if you have had the following psychiatric problems For any problem that you have NOT had, please indicate "never diagnosed". For any problems that you have had, please indicate if it was present before, during, and/or after Peace Corps (select all that apply).

	Never diagnosed	Before Peace Corps	During Peace Corps	After Peace Corps
Generalized anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major depressive disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Psychiatric problem (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 3: Health Questions – Psychiatric problems - Medication Y/N

Have you ever taken medication for your psychiatric problem(s)?

- Yes
- No
- Don't know

Peace Corps Health Outcomes

Section 3: Health Questions - Psychiatric problems - Medications

Please select any medications taken for your psychiatric problem(s), and if applicable indicate when taken. Select all that apply. Note that generic names are listed in alphabetical order with the brand name in bold.

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Amitriptyline (Elavil , Vanatrip)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amoxapine (Asendin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asenapine (Saphris)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bupropion (Aplenzihh , Budeprion , Buproban , Forfivo XL , Wellbutrin , Zyban)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Citalopram (Celexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clomipramine (Anafranil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clonazepam (Klonopin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clozapine (Clopine , Clozaril , Denzapine , FazaClo , Versacloz , Zaponex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Desipramine (Norpramin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Desvenlafaxine (Khedezla , Pristiq)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diazepam (Valium)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Divalproex sodium (Depakote)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doxepin (Silenor , Sinequan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Droperidol (Inapsine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duloxetine (Cymbalta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Escitalopram (Lexapro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluoxetine (Prozac , Sarafem , Selfemra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never taken	Before Peace Corps	During Peace Corps	After Peace Corps
Fluvoxamine (Luvox)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haloperidol (Haldol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imipramine (Tofranil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isocarboxazid (Marplan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maprotiline (Ludiomil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Midazolam (Versed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mirtazapine (Remeron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nefazodone (Serzone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nortriptyline (Aventyl, Pamelor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Olanzapine (Zyprexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paroxetine (Brisdelle, Paxil, Pexeva)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phenelzine (Nardil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phenobarbital (Luminal, Solfoton)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pimozide (Orap)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protriptyline (Vivactil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quetiapine (Seroquel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risperidone (Risperdal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Selegiline (Emsam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sertraline (Zoloft)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranylcypromine (Parnate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trazodone (Desyrel, Oleptro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trimipramine (Surmontil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venlafaxine (Effexor, Effexor XR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ziprasidone (Geodon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "other" please specify

Section 4: Risk Factors - Family History

This last group of questions will help us understand if you might be at higher risk for certain diseases.

Has anyone in your family (mother, father, brother, sister) ever been diagnosed with (check any that apply):

- Cancer
- Diabetes
- Heart problems (heart attack, irregular heartbeat, congestive heart failure)
- Psoriasis
- Psychiatric issues (ex: generalized anxiety disorder, major depressive disorder, bipolar, or schizophrenia)

Section 4: Risk Factors - Smoke

Have you smoked at least 100 cigarettes in your entire life?

NOTE: 5 packs = 100 cigarettes

- Yes
- No
- Don't know/not sure

Section 4: Risk Factors - Smoke

Do you now smoke cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all
- Don't know/ Not sure

During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

- Yes
- No
- Not applicable. I haven't smoked in the last 12 months.
- Don't know / Not sure

How long has it been since you last smoked a cigarette, even one or two puffs?

- Within the past month (less than 1 month ago)
- Within the past 3 months (1 month but less than 3 months ago)
- Within the past 6 months (less than 6 months ago)
- Within the past year (6 months but less than 1 year ago)
- Within the past 5 years (1 year but less than 5 years ago)
- Within the past 10 years (5 years but less than 10 years ago)
- 10 years or more
- Don't know/ Not sure

Section 4: Risk Factors - Alcohol

During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

- Yes
- No
- Don't know/ Not sure

Peace Corps Health Outcomes

Section 4: Risk Factors - Alcohol

During the past 30 days how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

(Please enter a number 0 or greater)

Days per week

Days per month

One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?

(Please enter a number 0 or greater)

Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks (for men) or 4 or more drinks (for women) on an occasion?

(Please enter a number, 0 or greater)

NOTE: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

During the past 30 days, what is the largest number of drinks you had on any occasion?

(Please enter a number, 0 or greater)

Section 5: Demographics

How many days per week do you exercise moderately or vigorously (physical exertion feels somewhat hard to hard) for at least 30 minutes? (Please enter a number 0 or greater)

What is the highest grade or year of school you completed?

- Grade 12 or GED (High school graduate)
- College 1 year to 3 years (Some college or technical school)
- College 4 years or more (College graduate)
- Graduate or Professional school

Are you currently...?

- Employed for wages
- Self-employed
- Out of work for 1 year or more
- Out of work for less than 1 year
- A Homemaker
- A Student
- Retired
- Unable to work

Are you...?

- Married
- Divorced
- Widowed
- Separated
- Never married
- A member of an unmarried couple

What is your age group?

- 21-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70+

Are you male, female, or other?

- Male
- Female
- Other
- Prefer not to answer

Are you Hispanic, Latino/a, or Spanish origin?

- Yes
- No
- Don't know/ Not sure

Which one or more of the following would you say is your race?

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Pacific Islander
- Don't know/ Not sure
- Other (please specify)

End of Survey

Thank you for helping to improve Peace Corps' understanding of the long term health outcomes among Peace Corps Volunteers.