Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____ Application Case ID:_____
(Mo/Day/Year)

Form Name
OMB No.:
Expiration Date:

HEALTH HISTORY FORM (PAPER COPY)

*Please note in several areas further information is requested requiring you to complete a written response, or write a personal statement to get further information on a reported condition. Please use back of this form, or another sheet of paper, if there is not sufficient room to provide all the requested information.

PRIVACY ACT NOTICE

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq. It will be used primarily for the purpose of determining your eligibility for Peace Corps service and, if you are invited to serve as a Peace Corps Volunteer, for the purpose of providing you with medical care during your Peace Corps service. Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Peace Corps Volunteer.

This information may be used for the purposes described in the Privacy Act, 5 USC 552a, including the routine uses listed in the Peace Corps' System of Records. Among other uses, this information may be used by those Peace Corps staff members who have a need for such information in the performance of their duties. It may also be disclosed to the Office of Workers' Compensation Programs in the Department of Labor in connection with claims under the Federal Employees' Compensation Act and, when necessary, to a physician, psychiatrist, clinical psychologist or other medical personnel treating you or involved in your treatment or care. A full list of routine uses for this information can be found on the Peace Corps website at http://multimedia.peacecorps.gov/multimedia/pdf/policies/systemofrecords.pdf.

BURDEN STATEMENT:

Public reporting burden for this collection of information is estimated to average 45 minutes per applicant. 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: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC 20526 ATTN: PRA (0420 - ####). Do not return the completed form to this address.

Application Case ID:

Authorization for Peace Corps Use of Medical Information

(Please sign this and return with your HHF. Keep a copy for your records)

WHY IS THE PEACE CORPS ASKING ME TO SIGN THIS AUTHORIZATION?

HIPAA — the Health Insurance Portability and Accountability Act — is a federal law which, together with related regulations, is designed in part to protect information about your health from unreasonable disclosure. It limits the extent to which your "protected health information" — individually identifiable information about your physical or mental health or the health care you have received — can be used without your consent for purposes other than medical treatment and payment, and related business operations. Since the Peace Corps provides medical care to Peace Corps Volunteers during their service, it is subject to HIPAA requirements. HIPAA requires individuals to be given a notice describing how medical professionals and health plans use their medical information. The Peace Corps' notice is available on its website at **www.peacecorps.gov/policies/pdf/hipaa.pdf**

Since Peace Corps Volunteers often live and work in remote areas with less sophisticated sanitation and health-care networks, and higher levels of endemic diseases, than are typical in the United States, all applicants must receive medical clearance before joining the Peace Corps. Your medical status may also have a bearing on the location of your Peace Corps assignment. The Peace Corps needs access to information about your medical history and current medical condition, including the answers you provide on this Health History Form and other information collected during the Peace Corps' medical clearance process, to determine whether you are medically eligible for Peace Corps service and, if so, where you will be placed as a Volunteer.

Because HIPAA puts strict limits on the use of your protected health information, the Peace Corps must have a signed authorization from you to use that information for purposes other than medical treatment and payment. Therefore, **unless you sign this authorization, the Peace Corps will not be able to consider your application for Peace Corps service.**

In addition, if you are offered and accept an invitation to become a Peace Corps Volunteer, the information collected during the medical clearance process will become part of your Peace Corps medical record. The Peace Corps medical staff will add information to your medical record as they care for you. As a Peace Corps Volunteer, the Peace Corps will be responsible for your medical care and Peace Corps medical staff will, as permitted by HIPAA, use your health information for medical treatment and payment. However, the Peace Corps has other responsibilities, including training Volunteers, protecting their safety and security, providing program support to them overseas and ensuring that the whole Peace Corps system operates as effectively and efficiently as possible. There may, therefore, be situations in which Peace Corps non-medical staff needs your health information for purposes other than medical treatment or payment.

Under the Peace Corps' medical confidentiality policy, your health information may be disclosed to Peace Corps non-medical staff only if they have a **specific** need to know the information to do their jobs. This might include situations in which the Country Director at your post needs medically confidential information in order to manage the post. Only the minimum amount of information necessary will be disclosed and recipients are required to protect the confidentiality of the health information they receive.

The following are some specific examples of health information that may be disclosed to Peace Corps non-medical staff if they have a specific need to know the information to do their jobs:

- evidence of illegal or unauthorized drug use;
- the existence of a medical condition for which you require accommodation, along with the nature of the accommodation;
- information relating to a serious threat to your health or safety or that of any other person;
- information about your non-compliance with medical advice or policies that pose a serious risk of harm to you or someone else;
- the fact that you have been the victim of a physical or sexual assault;
- information needed to ensure proper arrangements for a medical evacuation;
- information about a medical condition if needed to ensure your safety and security or that of another person;
- information about a medical condition that is affecting your performance or well-being;
- information about risky sexual or other behavior that is putting you or someone else at serious risk; and
- information relating to your provision of any misleading, inaccurate or incomplete medical information to the Peace Corps during the application process.

You may revoke this authorization at any time. However, **because this authorization is needed in order for the Peace Corps to administer its program, you may continue to serve as a Volunteer only for as long as this authorization remains in effect.**

Application Case ID:

This authorization permits the Peace Corps to use my protected health information to determine my eligibility for the Peace Corps and as necessary for administration of the Peace Corps program. I understand that **this document must be signed, dated, and returned with my medical information, and that the Peace Corps will be unable to review my information without this signed document.**

I, hereby authorize that:

A. All health information I provide to the Peace Corps or that is provided by anyone who has provided health care services or treatment to me, consulted on such services, or otherwise has health care information responsive to the information requests of the Peace Corps, including my response to the Health History form, and any follow-up health information requested by and provided to the Peace Corps Office of Volunteer Support relating to me prior to my being sworn in as a Peace Corps Volunteer (including but not limited to information about my prior physical and mental health history, my current health status, and possible future care and treatment), may be disclosed to the following people:

Peace Corps staff, including in the Office of Volunteer Support , Office of Volunteer Recruitment Selection, Office of Global Operations, Office of Safety and Security, Office of General Counsel, Peace Corps Medical Officers, Country Directors at overseas posts, and any other Peace Corps staff or contractors who have a specific need to know the information to perform their duties, for the purposes of making a determination of my medical or other eligibility for Peace Corps service and of placement/assignment.

B. If I am accepted for Peace Corps service, the information listed above will become part of my Peace Corps health record. All information in my Peace Corps health record, and any other personal health information relevant to me that is provided to the Peace Corps by me or any health care provider or other person, may be disclosed to Peace Corps staff or contractors, as described in paragraph A above, who have a specific need to know the information for the purposes of performing their duties in connection with administration of the Peace Corps program only. This may include (but is not limited to) information relevant to my continued service as a Peace Corps trainee or Peace Corps Volunteer.

This authorization is effective until five years following either my close of Peace Corps service or final determination by the Peace Corps that I am not eligible for Peace Corps service. I understand that I may revoke this authorization at any time by sending a written revocation to the Office of Volunteer Support, Peace Corps, 1111 20th Street, NW, Washington DC, 20526, but that my revocation before acceptance will stop consideration of my application, and that my service as a Volunteer is conditioned on the existence of this authorization, which is necessary to administer the Peace Corps program.

I also understand that during the entire period of this authorization to use my health care information, Peace Corps will protect the confidentiality of my health care information, consistent with the Privacy Act, the Health Insurance Portability and Accountability Act (as applicable), and Peace Corps policies on confidentiality of medical information, as described in the Peace Corps Notice of Privacy Practices and Peace Corps Manual Section 268.

I have read and understand this authorization.

Signature:_____Date of Birth: _____

Application Case ID: _____

OPENING QUESTIONS

How tall are you? (Height in inches) _____

How much do you weigh? (Weight in pounds) _____

Have you ever filled out a Health History Questionnaire for the Peace Corps before? ☐ Y ☐ N

If Yes, please indicate the year: _____

I have been diagnosed with cancer (of any type) in my lifetime. ☐ Y ☐ N

Date of Diagnosis (month/year): _____

Type of Cancer: _____

REPORT OF CURRENT MEDICATIONS

Do you take any prescription medications? ☐ Y ☐ N

If Yes, please include the name, route (oral, inhaled, injected, etc.), start date, dosage (e.g. 50 mg), and frequency (e.g. every day, as needed, etc.)_____

_____

_____

_____

_____

Do you regularly take any over the counter medications or herbal remedies? ☐ Y ☐ N

If Yes, please include the name, route (oral, inhaled, injected, etc.), start date, dosage (e.g. 50 mg), and frequency (e.g. every day, as needed, etc.)_____

_____

_____

_____

_____

Has your doctor changed your medication or have you stopped taking a medication in the last 6 months? ☐ Y ☐ N

If Yes, please list each medication that was changed or that you stopped taking and the reason the medication regime was changed or stopped._____

_____

_____

_____

_____

REPORT OF PHYSICAL ABILITIES

Peace Corps Volunteers serve in conditions or countries that may include remote locations with rugged terrain or city sites that require climbing up steep, multiple floor steps while carrying groceries. Sometimes access to water is limited and walking with buckets of water may be a daily task. Transportation may mean walking on rough roads, biking on rugged terrain, or relying on mass transportation with waits up to several hours in weather that is extremely hot or cold. Ice and snow or constant dust with relentless dry heat or oppressive humidity is common. The questions below are used to determine your ability to accommodate such conditions, and make placement decisions as appropriate.

Application Case ID: _____

Please answer the following statements (if you mark "No," a description is required):

I can walk distances on rough or uneven terrain. ☐ Y ☐ N

If no, describe why not: _____

_____

_____

I can climb at least 2 flights of stairs carrying groceries or luggage without difficulty. ☐ Y ☐ N

If no, describe why not: _____

_____

_____

I can tolerate riding in a vehicle on rough roads. ☐ Y ☐ N

If no, describe why not: _____

_____

_____

I can ride a bicycle. ☐ Y ☐ N

If no, describe why not: _____

_____

_____

I can ride a bicycle <u>on rough roads.</u> ☐ Y ☐ N

If no, describe why not: _____

_____

_____

I can hold a squatting position for several minutes. ☐ Y ☐ N

If no, describe why not: _____

_____

_____

I can lift (check the highest weight you can lift without difficulty):

☐ 10 pounds ☐ 20 pounds ☐ 50 pounds

I cannot tolerate living in conditions (check all that apply) :

☐ Heat > 90 degrees ☐ Cold < 20 degrees ☐ Constant Dampness ☐ Constant Dust

If any of the above boxes are checked, please describe why you cannot live in those environments: _____

_____

_____

I can tolerate living at an altitude 5000 feet above sea level. ☐ Y ☐ N

If no, describe why not: _____

_____

_____

Application Case ID: _____

You must answer one of the two questions below:

I have no limitations on my functional abilities to meet my activities of daily living. ☐ Y ☐ N

I have some limitations on my funcitonal abilitites to meet my activities of daily living. ☐ Y ☐ N

Describe the limitations on your functional abilities:_____

_____

_____

ALLERGY (Condition of Allergic Response)

ALLERGY SHOTS

I currently receive allergy shots. ☐ Y ☐ N

If yes, please record expected date of last treatment (month/year):_____

LIFE THREATENING REACTIONS

In my lifetime, I have experienced a life threatening allergic reaction with some or all of these symptoms: swelling of the mouth, tongue, lips and/or difficulty breathing, loss of consciousness, and/or severe drop in blood pressure. ☐ Y ☐ N

If yes, please answer all of the following questions.

Describe the allergen, your reaction, and the date of last reaction. _____

_____

_____

My reaction required an Emergency Room visit or hospitalization. ☐ Y ☐ N

I will need special placement due to my allergic reaction to this allergen. ☐ Y ☐ N

MARK ALL ALERGIES YOU HAVE:

FOOD ALLERGENS

Peanut or Nut Allergy ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Milk or Dairy Allergy ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Other Food Allergy ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

MEDICATION ALLERGENS

Penicillin Allergy ☐ Y ☐ N

Application Case ID: _____

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Sulfa Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Tetracycline Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Other Medication Allergy(ies)*

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

I am allergic to three or more types of antibiotics. (Complete this section in full even if you have already reported an allergic reaction). ☐ Y ☐ N

I know what antibiotics I can safely take, should I develop an infection while in Peace Corps. ☐ Y ☐ N

(If yes, list the antibiotics you can safely take below) _____

_____

_____

ANIMAL ALLERGENS

Bee or Wasp Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Cat Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Dog Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Other Animal Allergy(ies) ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

ENVIRONMENT ALLERGENS

Dust Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Mold Allergy ☐ Y ☐ N

Describe your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Seasonal Allergy (Pollen, Trees, etc.) ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Other Environment Allergy(ies) not previously listed ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

OTHER ALLERGENS

Other Allergy(ies) not previously listed. ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction (month/year). _____

_____

_____

Any other condition not previously listed that you have sought medical attention by an allergy specialist within the <u>past two years.</u> ☐ Y ☐ N

Describe the allergen, your reaction, recommended treatment, and the date of last reaction. _____

_____

_____

CARDIOVASCULAR (CONDITIONS OF THE HEART OR BLOOD VESSELS)

Have you ever had any of the following?

☐ **Heart or Major Vessel Surgery**

Type of Surgery:_____

Date of Surgery (month/year):_____

The last time you saw a Health Care provider in relation to this surgery (month/year): _____

☐ **Heart Attack**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Congestive Heart Failure**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Cardiomyopathy**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Endocarditis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Pulmonary Embolism**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **A Pacemaker**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **An Implantable Defibrillator**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Coronary Artery Disease**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **A Heart Defect present since birth that requires specialized care**

Describe:_____

The last time you saw a Health Care provider for this condition (month/year):_____

☐ **I am currently taking a blood thinning medication, other than aspirin.**

Please list your blood thinning medications. Separate individual medications with a comma. _____

_____

_____

☐ **I am 50 years of age or older.**

☐ **I have had an electrocardiogram (ECG) in the last six months.**

Application Case ID: _____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Cardiologist for a heart or blood vessel condition. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Low Blood Pressure**

☐ Y ☐ N **High Blood Pressure**

☐ Y ☐ N **High Cholesterol**

☐ Y ☐ N **High Triglycerides**

☐ Y ☐ N **Peripheral Vascular Disease**

☐ Y ☐ N **Varicose Veins**

☐ Y ☐ N **Raynaud's Syndrome**

☐ Y ☐ N **Heart Conduction conditions (such as palpitations or bundle branch blocks)**

☐ Y ☐ N **Heart Valve Disorder**

☐ Y ☐ N **Pulmonary Valve Disorder**

☐ Y ☐ N **Any cardiac symptoms (such as fainting or chest pain), diagnosed condition, or cardiac surgery not previously listed**

If "Yes" list condition:_____

_____

_____

If you answered yes to any of the diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year): _____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

Application Case ID: _____

DERMATOLOGY (Conditions of the Skin)

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or a Dermatologist for any condition of the skin ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Cystic Acne**

☐ Y ☐ N **Vulgaris Acne**

☐ Y ☐ N **Unknown Type Acne**

☐ Y ☐ N **Alopecia (Hair Loss)**

☐ Y ☐ N **Pilonidal Cyst**

☐ Y ☐ N **Dermatitis**

☐ Y ☐ N **Dry Skin**

☐ Y ☐ N **Eczema**

☐ Y ☐ N **Psoriasis**

☐ Y ☐ N **Basal cell tumor of the skin**

☐ Y ☐ N **Squamous cell tumor of the skin**

☐ Y ☐ N **Moles or Nevi (These do NOT include any basal or squamous cancers listed above)**

☐ Y ☐ N **Fungal Infections, including Nail Fungal infections**

☐ Y ☐ N **Any skin symptom (such as a rash or itching), diagnosed condition, or skin surgery not previously listed**

If "Yes" list condition: _____

_____

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

ENDOCRINOLOGY (Diabetes or Conditions of the Pituitary, Thyroid, Parathyroid, and Adrenal Glands)

HAVE YOU EVER HAD ANY OF THESE CONDITIONS IN YOUR LIFETIME?

☐ **Addison's Disease (hypo-adrenal glands and/or reduced corticosteroid levels)**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Cushing's Disease (hyper-adrenal glands and/or elevated corticosteroid levels)**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Diabetes Type I**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Congenital Adrenal Hyperplasia**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Endocrinologist or other specialist for a condition of the Endocrine System (diabetes or conditions of the pituitary, thyroid, parathyroid and adrenal glands for example). ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Diabetes Mellitus Type 2**

☐ Y ☐ N **Hypoglycemia**

☐ Y ☐ N **Hyperthyroidism (overactive thyroid)**

☐ Y ☐ N **Grave's Disease (an autoimmune response leading to an overactive thyroid)**

☐ Y ☐ N **Thyroid Storm (a life-threatening event of an overactive thyroid)**

☐ Y ☐ N **Hypothyroidism (underactive thyroid)**

☐ Y ☐ N **Hashimoto's or other type of Thyroiditis**

☐ Y ☐ N **Underactive thyroid due to a pituitary dysfunction**

☐ Y ☐ N **Acromegaly (growth hormone secreting pituitary tumor)**

☐ Y ☐ N **Prolactin-secreting pituitary tumor**

☐ Y ☐ N **ACTH-producing pituitary tumor**

☐ Y ☐ N **Non-functioning (no production of hormones) pituitary tumor**

☐ Y ☐ N **Hypoarathyroidism (underactive parathyroid)**

☐ Y ☐ N **Hyperparathyroidism (overactive parathyroid)**

☐ Y ☐ N **Pheochromocytoma**

☐ Y ☐ N **Gout (If you have already answered yes for this condition in another body system, leave blank)**

☐ Y ☐ N **Any endocrine symptom (such as hormonal abnormalities), diagnosed condition, or endocrine surgery not previously listed for which you have sought medical attention in the past 2 years.**

If "Yes" list condition: _____

_____

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year): _____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

EAR, NOSE, AND THROAT (Conditions of the Ear, Nose, and Throat)

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

☐ Y ☐ N **I am hard of hearing and I use speech as my primary form of communication**

☐ Y ☐ N **I am deaf and use American Sign Language as my primary form of communication**

☐ Y ☐ N **I am deaf and use speech and residual hearing as my primary form of communication**

☐ Y ☐ N **I have no difficulty hearing**

If you answered yes to any of the diagnoses (except the last question), please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____ Ear(s) affected:_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

Application Case ID: _____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Ear, Nose, and Throat Specialist for an Ear, Nose, and/or Throat condition. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Cholesteatoma (usually a benign tumor of the ear)**

☐ Y ☐ N **Meniere's Disease (affects balance and hearing)**

☐ Y ☐ N **Vertigo (dizziness)**

☐ Y ☐ N **Tinnitus (ringing in the ear)**

☐ Y ☐ N **Ear Infection**

☐ Y ☐ N **Sinusitis**

☐ Y ☐ N **Tonsillitis**

☐ Y ☐ N **Deviated septum**

Any other symptom or condition of the ear, nose, or throat (including surgeries) not previously listed that has required you to seek medical attention in the past 2 years ☐ Y ☐ N

If "Yes" list condition: _____

_____

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year): _____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

GASTROENTEROLOGY (CONDITIONS OF THE COLON, STOMACH, PANCREAS, OR LIVER)

IN MY LIFETIME I HAVE/HAD:

☐ **Cirrhosis of the Liver**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Esophageal Varices**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Ascites**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Hepatitis C**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Active Hepatitis B OR I am a Hepatitis B carrier**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **I have undergone Bariatric Surgery for weight loss**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Any absorption disorder, such as Crohn's Disease or Ulcerative Colitis**

List condition: _____

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **I currently have a Colostomy, Ileostomy, or any other surgical repair of the colon that requires daily care and maintenance**

The last time you saw a Health Care provider for this condition: _____

PLEASE ANSWER THE STATEMENT BELOW: (MUST CHECK "YES" OR "NO")

☐ Y ☐ N **I am 50 years of age or older**

In the defined time frames, I have had a: (check all that apply)

☐ **Colonoscopy (within 10 years)** ☐ My test was abnormal and required further follow up testing

☐ **Flexible Sigmoidoscopy (within 5 years)** ☐ My test was abnormal and required further follow up testing

☐ **Double Contrast Barium Enema (within 5 years)** ☐ My test was abnormal and required further follow up testing

☐ **CT Colonography "Virtual Colonoscopy" (within 5 years)** ☐ My test was abnormal and required further follow up testing

☐ **Stool for DNA testing (within 1 year)** ☐ My test was abnormal and required further follow up testing

☐ **Fecal Immunochemical Test (within 1 year)** ☐ My test was abnormal and required further follow up testing

☐ **Fecal Occult Blood Test x 3 (within 1 year)** ☐ My test was abnormal and required further follow up testing

☐ **I have not had any of the listed tests above within the defined time frames**

Application Case ID: _____

PLEASE ANSWER THE STATEMENTS BELOW: (CHECK "YES" OR "NO" FOR EACH QUESTION BELOW)

☐ Y ☐ N **I am able to tolerate lactose in my diet and do not avoid dairy products**

☐ Y ☐ N **I am able to tolerate gluten in my diet and do not avoid foods containing gluten**

<u>If you answered no to either of the above questions regarding diet modifications</u>, please record the date of initial symptoms and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Gastroenterologist for a Colon, Stomach, Pancreas, or Liver condition. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

For each Diagnosis listed circle Yes or No:

☐ Y ☐ N **Hepatitis (inflammation of the liver) If you have already answered yes for this condition in another body system, leave blank)**

☐ Y ☐ N **Irritable Bowel Syndrome**

☐ Y ☐ N **Bowel Obstruction**

☐ Y ☐ N **Inguinal Hernia (protrusion of abdominal contents into lower abdomen)**

☐ Y ☐ N **Celiac Disease**

☐ Y ☐ N **Cholelithiasis (Gallbladder stones)**

☐ Y ☐ N **Cholecystitis (inflammation of the gallbladder)**

☐ Y ☐ N **Cholangitis (Infection of the biliary tract)**

☐ Y ☐ N **Cholecystectomy (Surgical removal of the gallbladder)**

☐ Y ☐ N **Pancreatitis (Inflammation of the pancreas)**

☐ Y ☐ N **Colonic Polyps and/or Polypectomy**

☐ Y ☐ N **Gastroesophageal Reflux Disease (Heartburn)**

☐ Y ☐ N **Hiatal Hernia (protrusion of the stomach into the chest cavity)**

☐ Y ☐ N **Diverticulosis (bulging small pouches in the lining of the colon)**

☐ Y ☐ N **Esophagitis (inflammation or swelling of the esophagus)**

☐ Y ☐ N **Peptic Ulcer (a mucosal break in the stomach or small intestine)**

☐ Y ☐ N **Gastritis (inflammation of the mucosa of the stomach)**

☐ Y ☐ N **Hemorrhoids**

☐ Y ☐ N **Abdominal Pain (check only if you have not already reported this condition above**

Any other Colon, Stomach, Pancreas, or Liver Condition (including surgeries) not previously listed for which you have sought medical attention in the past 2 years ☐ Y ☐ N

If "Yes" list condition: _____

_____

If you answered yes to any of the diagnoses above, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis:_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

RHEUMATOLOGY AND IMMUNOLOGY (DISEASES CAUSED BY AN OVERACTIVE IMMUNE SYSTEM AND CHRONIC INFLAMMATION)

IN MY LIFETIME I HAVE BEEN DIAGNOSED WITH:

☐ **Ankylosing Spondylitis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Systemic Lupus Erythematosus**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Polymyositis; Dermatomyositis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Scleroderma**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Psoriatic Arthritis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Fibromyalgia**

☐ Y ☐ N **Chronic Fatigue Syndrome**

☐ Y ☐ N **Rheumatoid Arthritis**

☐ Y ☐ N **Juvenile Rheumatoid Arthritis**

If you answered yes to Fibromyalgia, Chronic Fatigue Syndrome, Rheumatoid Arthritis, or Juvenile Rheumatoid Arthritis, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis:_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician, Immunologist, or Rheumatologist for any condition caused by chronic inflammation from an overactive immune system or ailments of the joints such as arthritis. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Reactive Arthritis (Reiter's Syndrome)**

☐ Y ☐ N **Sjörgren's Syndrome**

☐ Y ☐ N **<u>Any rheumatoid or immunologic symptom, diagnosed condition, or surgery</u>** not previously listed for which you have sought medical attention **<u>in the past two years.</u>**

If "Yes" list condition: _____

_____

Application Case ID: _____

If you answered yes to any of the diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe._____

_____

_____

NEUROLOGY (CONDITIONS OF THE BRAIN OR NERVOUS SYSTEM)

IN MY LIFETIME I HAVE HAD:

☐ **Amyotrophic Later Sclerosis (ALS)**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Multiple Sclerosis (MS)**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Parkinson's Disease**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Myasthenia Gravis**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Cerebral Palsy (CP)**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Muscular Dystrophy (MD)**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Cerebral Vascular Accident (CVA)**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Surgery and placement of a Ventricular Shunt**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Tourette's Syndrome**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Sleep Apnea that requires or may require in the next three years a C-PAP machine**

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Seizure disorder (other than a seizure as a baby caused by high fever)**

List:_____

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

☐ **Any Myopathy (a neuromuscular disorder) not previously listed**

List:_____

Date of Diagnosis (month/year):_____ Last seen by a physician for this condition (month/year): _____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Neurology (Brain or Nervous System) specialist for a condition of the Brain or Nervous System. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Bell's Palsy**

☐ Y ☐ N **Migraine or other severe Headaches**

☐ Y ☐ N **Sleep Apnea (If you have already answered yes for this condition in another body system, leave blank)**

☐ Y ☐ N **Narcolepsy**

☐ Y ☐ N **Insomnia**

Any other symptom, condition, or surgery of the Brain or Nervous System <u>(not previously listed)</u> for which you have sought medical attention in the past two years. ☐ Y ☐ N

If Yes, list condition: _____

_____

If you answered yes to any of the diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

Application Case ID: _____

MUSCULOSKELETAL (CONDITIONS OF THE MUSCLE, BONE, TENDON, OR LIGAMENT)

I HAVE HAD ORTHOPEDIC SURGERY IN MY LIFETIME AND HARDWARE (E.G. PINS, RODS, JOINT REPLACEMENT) WAS LEFT IN PLACE. ☐ Y ☐ N

If yes, please list type of surgery(ies) as well as date of surgery, reason for surgery, and what hardware was left in place._____

_____

_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician, Orthopedic Surgeon, or other Health Care Provider (e.g. Physical Therapist or Chiropractor). ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each condition listed check Yes or No:

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Back or Spine**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Neck**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Skull**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Knee**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Shoulder**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Hand or Wrist**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Hip or Pelvis**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Foot or Ankle**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Elbow**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Arm**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Leg**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Fingers**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for the Toes**

☐ Y ☐ N **Any injury, surgery, or pain (on a regular or intermittent basis), or for any reason sought medical care for <u>any other muscle, bone, tendon, or ligament</u>**

If "Yes" list condition: _____

_____

☐ Y ☐ N **Gout (If you have already answered yes for this condition in another body system, leave blank)**

☐ Y ☐ N **Osteoporosis (decrease bone mass with increased risk for bone fracture)**

☐ Y ☐ N **Osteopenia (low bone mass)**

☐ Y ☐ N **Degenerative Disc Disease (changes to the spinal discs)**

☐ Y ☐ N **Degenerative Joint Disease (Osteoarthritis)**

☐ Y ☐ N **Scoliosis (curvature of the spine)**

☐ Y ☐ N **Kyphosis (bowing of the spine)**

☐ Y ☐ N **Any other muscle, bone, tendon, or ligament symptom, diagnosed condition or orthopedic surgery not previously listed for which you have sought medical attention in the past 2 years.**

If "Yes" list condition: _____

_____

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

INFECTIOUS DISEASE (CONDITIONS OF INFECTIOUS PROCESS)

IN MY LIFETIME, I HAVE BEEN DIAGNOSED WITH:

☐ **Human Immunodeficiency Virus (HIV)**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Hepatitis C**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

Application Case ID: _____

☐ **I have had a positive PPD and completed a full course of medication for latent Tuberculosis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **I have had a positive PPD and have not been treated for Tuberculosis**

Date:_____ Reason not given treatment:_____

Reason not given treatment: _____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Infectious Disease Specialist for an Infectious Disease. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Any Sexually Transmitted Disease for which you have sought medical attention in the past two years**

☐ Y ☐ N **Lyme Disease**

☐ Y ☐ N **Hepatitis (inflammation of the liver) If you have already answered yes for this condition in another body system, leave blank)**

☐ Y ☐ N **Any other Infectious Disease condition or symptom <u>not previously listed</u> for which you have sought medical attention, in the <u>past two years</u> (does <u>not</u> include self limiting conditions such as a cold, flu, or simple infections)**

If "Yes" list condition: _____

_____

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

HEMATOLOGY (CONDITIONS OF THE BLOOD)

IN MY LIFETIME I HAVE HAD: (CHECK ALL THAT APPLY)

☐ **My spleen removed**

Date of Diagnosis (month/year):_____ Reason for removal: _____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

☐ **A G6PD deficiency (If you do not know, do not check this box)**

☐ **Essential (Primary) Thrombocythemia**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Polycythemia Vera**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Agnogenic Myeloid Metaplasia**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Myelofibrosis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Sickle Cell Thalassemia, Hemoglobin C or SC (DISEASE NOT TRAIT)**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Hemophilia**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Hemochromatosis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Lymphoma (Hodgkin Disease, Non-Hodgkin Lymphomas, Multiple Myeloma)**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Hemolytic Anemia (breakdown of red blood cells due to a disease process)** ☐ Y ☐ N

(if yes to Hemolytic Anemia then check one of the three options below)

Application Case ID: _____

☐ Y ☐ N **Diagnosis: Auto-Immune Hemolytic Anemia** Date of Diagnosis:_____

☐ Y ☐ N **Diagnosis: Hereditary Hemolytic Anemia** Date of Diagnosis:_____

☐ Y ☐ N **Diagnosis: Other Hemolytic Anemia** Date of Diagnosis:_____

☐ Y ☐ N **Diagnosis: A condition that stops the blood from clotting and results in abnormal or frequent bleeding** Date of Diagnosis:_____

If you answered yes to <u>any Anemia or blood clotting symptom</u>, please record the date of diagnosis (if known) and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

PLEASE ANSWER THE QUESTIONS BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Iron Deficiency Anemia**

☐ Y ☐ N **Megaloblastic or Pernicious Anemia (B-12 and/or Folate Deficiency)**

☐ Y ☐ N **Aplastic Anemia (decreased stem cell production)**

☐ Y ☐ N **Anemia caused by another condition (e.g. kidney disease)**

☐ Y ☐ N **Anemia caused by blood loss (e.g. bleeding ulcer)**

☐ Y ☐ N **A bleeding problem due to a specific medication**

☐ Y ☐ N **Any condition of the Spleen**

☐ Y ☐ N **Any other symptom, diagnosed condition, or surgery of the blood not previously listed for which you have sought medical attention in the past 2 years**

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

GYNECOLOGY (CONDITIONS OF THE FEMALE BREAST AND FEMALE REPRODUCTIVE TRACT)

IF YOU ARE FEMALE, PLEASE COMPLETE THE FOLLOWING QUESTIONS; IF YOU ARE MALE, SKIP TO THE NEXT SECTION.

The Peace Corps offers routine Mammogram screenings for women who are 50 years of age or older during their service. Not all countries have the capabilities to provide routine screening Mammograms.

You must select one of the options below.

☐ **I will be 50 years of age or older during the time of my Peace Corps service. I would like to have a routine Mammogram Screening during my service.**

☐ **I will be 50 years of age or older during the time of my Peace Corps service. I would like to waive my routine Mammogram while in service. I realize that if I have risk factors or if my physician is in disagreement with this decision, I will be offered routine Mammogram screenings.**

☐ **I will be under 50 years of age during the time of my Peace Corps service.**

Check all that apply

I have had a Mammogram. ☐ Y ☐ N Date NEXT Mammogram is due (month/year):_____

☐ **I'm currently on birth control (Identify method below)**

NOTE: Peace Corps will prescribe generic equivalents for most medications. Some methods of contraception are not available in many countries. These are noted below.

☐ **Oral Contraceptive**

☐ **Seasonale**

☐ **Depo Provera Injections (Note: most likely unavailable)**

☐ **Nuva Ring (Note: most likely unavailable)**

☐ **Cervical Cap (Note: most likely unavailable)**

☐ **Diaphragm (Note: most likely unavailable)**

☐ **Intrauterine Device (IUD)**

☐ **Implanon (Note: Peace Corps does not support this method of contraception)**

☐ **Birth Control Patch (Note: most likely unavailable)**

☐ **Other (Please elaborate):** _____

Application Case ID: _____

Check all that apply

I have had a PAP test <u>in my lifetime.</u> ☐ Y ☐ N

If yes, please describe the results of your **<u>most recent</u>** PAP test._____

_____

Date NEXT PAP is due (mark N/A if you do not have a cervix and do not have PAPs)_____

I have had breast implants. ☐ Y ☐ N (if Yes complete 2 questions below)

Type of implant: _____ Date of surgery:_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Gynecologist for a condition of the female breast and/or female reproductive organs. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Breast Lump**

☐ Y ☐ N **Fibrocystic Breasts**

☐ Y ☐ N **Abnormal Menstrual Cycles (such as no bleeding, infrequent bleeding, heavy bleeding, or painful bleeding)**

☐ Y ☐ N **Polycystic Ovarian Disease (PCOS)**

☐ Y ☐ N **Pelvic Inflammatory Disease**

☐ Y ☐ N **Ovarian Cyst(s)**

☐ Y ☐ N **Endometriosis (Uterine lining growing outside of uterus)**

☐ Y ☐ N **Endometrial Hyperplasia (Excessive proliferation of the uterine lining**

☐ Y ☐ N **Any <u>gynecological symptom, diagnosed condition, or gynecological surgery not previous listed</u> that you have sought medical attention for in <u>the past two years.</u> (Excluding easily treated sexually transmitted disease)**

If Yes, list condition:_____

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form).

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

RESPIRATORY (CONDITIONS OF BREATHING AND THE LUNGS)

IN MY LIFETIME I HAVE HAD:

☐ **Chronic Obstructive Pulmonary Disease (COPD)**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Emphysema**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Pulmonary Embolism**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Sarcoidosis of the lungs and take steroids for this condition**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Cystic Fibrosis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician, Allergist, or Pulmonologist for a lung condition. ☐ Y ☐ N

Date of Visit(s) _____ Reason for Visit(s) _____

Date of Visit(s) _____ Reason for Visit(s) _____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Asthma**

☐ Y ☐ N **Bronchiectasis (widening of the airways)**

☐ Y ☐ N **Pneumonia (inflammation of the lungs)**

☐ Y ☐ N **Pneumothorax (Partial or total lung collapse)**

☐ Y ☐ N **Sleep Apnea (If you have already answered yes for this condition in another body system, leave blank)**

☐ Y ☐ N **Bacterial or Viral Respiratory Infections**

☐ Y ☐ N **Any other Respiratory symptom, condition, or surgery not previously listed for which you have sought medical attention in the past two years.**

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

UROLOGY AND NEPHROLOGY (CONDITIONS OF THE URINARY TRACT, BLADDER, OR KIDNEY)

IN MY LIFETIME I HAVE/HAD:

☐ **Nephrectomy, Solitary or Horseshoe Kidney**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Cystic Disease of the Kidney**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Glomerulonephritis**

Date of Diagnosis (month/year):_____ Acute OR Chronic:_____

The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Nephritis, Renal Failure**

Date of Diagnosis (month/year):_____ Acute OR Chronic:_____

The last time you saw a Health Care provider for this condition (month/year):_____

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician, Allergist, or Pulmonologist for a lung condition. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

Date of Visit(s) (month/year) _____ Reason for Visit(s)_____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **Cystitis (Urinary Tract Infection, Bladder Infection)**

☐ Y ☐ N **Prostatitis (Prostate Infection)**

☐ Y ☐ N **Urethritis (Inflammation of the Urethra)**

☐ Y ☐ N **Cystocele (weakened, stretched bladder)**

☐ Y ☐ N **Stress Incontinence (loss of urinary control)**

☐ Y ☐ N **Epididymitis (inflammation or infection of Epididymis)**

☐ Y ☐ N **Undescended Testicle**

☐ Y ☐ N **Hydrocele (a fluid-filled sac in the scrotum)**

☐ Y ☐ N **Spermatocele (a lump or bulge in the scrotum)**

☐ Y ☐ N **Variococele (enlarged veins in the scrotum)**

☐ Y ☐ N **Testicular Torsion (twisting of the spermatic cord)**

☐ Y ☐ N **Kidney and/or Urethral Stones**

☐ Y ☐ N **Urethral Stricture (Obstruction)**

☐ Y ☐ N **Pyelonephritis (infection of the kidney and/or ureters)**

☐ Y ☐ N **Benign Prostatic Hypertrophy (BPH) (enlargement of the prostate gland)**

☐ Y ☐ N **Any other Kidney, Bladder, Urinary Tract symptom, condition, or surgery of the Genitourinary system not previously listed for which you have sought medical attention in the past two years.**

If you answered yes to any of the diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

OPHTHALMOLOGY (CONDITIONS OF THE EYE)

IN MY LIFETIME I HAVE/HAD:

☐ **Macular Degeneration**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Lattice Degeneration**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Herpes Simplex Keratitis**

Date of Diagnosis (month/year):_____ The last time you saw a Health Care provider for this condition (month/year):_____

☐ **Irreversible Blindness**

Date of Diagnosis (month/year):_____ Left, Right, OR Both:_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.

- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

Please answer the following question:

I require prescription eye correction (either glasses or contacts). ☐ Y ☐ N

Note: Peace Corps does not support and strongly discourages the use of contact lenses due to conditions of service.

PLEASE ANSWER THE QUESTION BELOW. IF YES, COMPLETE ALL THE FOLLOWING QUESTIONS; IF NO, SKIP TO THE NEXT BODY SYSTEM.

In the past two years I have seen a Primary Care Physician or Ophthalmologist for an eye condition. ☐ Y ☐ N

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

Date of Visit(s) (month/year) _____ Reason for Visit(s) _____

For each Diagnosis listed check Yes or No:

☐ Y ☐ N **I have had Vision Correction Surgery such as Lasik**

☐ Y ☐ N **Retinal Detachment**

☐ Y ☐ N **Retinitis Pigmentosa**

☐ Y ☐ N **Cataracts**

☐ Y ☐ N **Cataract Surgery**

☐ Y ☐ N **Blepharitis (inflammation of the eyelash follicles)**

☐ Y ☐ N **Conjunctivitis (inflammation of the conjunctiva)**

☐ Y ☐ N **Chalazion (bump on eyelid due to blocked gland of the eye**

☐ Y ☐ N **Hordeolum (infection at the base of the eyelashes**

☐ Y ☐ N **Glaucoma**

☐ Y ☐ N **Uveitis (inflammation of the eye)**

☐ Y ☐ N **Optic Nerve Disease**

☐ Y ☐ N **Pterygium (a noncancerous clear growth located on the top of the eye membrane)**

☐ Y ☐ N **Any other eye symptoms, diagnosed condition, or eye surgery not previously listed for which you have sought medical attention in the past two years.**

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year):_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

MENTAL HEALTH (CONDITIONS OF MENTAL HEALTH)

Please be candid when answering the questions below. There are many assignments where you may be very isolated, or exposed to violence and crime, extreme poverty, or inequitable treatment. In many countries, there is limited access to western-trained mental health professionals and you may not be able to receive adequate support for existing mental health symptoms or new mental health needs.

In my lifetime I have/had:

☐ **Bipolar Disorder**

Date of diagnosis (month/year): _____

☐ **Schizophreniform Disorder, Schizophrenia, Schizoaffective Disorder**

Date of diagnosis (month/year): _____

☐ **Hospitalization for mental health**

Date (month/year): _____ Diagnosis: _____

☐ **Suicide Attempt**

Date (month/year): _____ Course of Treatment: _____

☐ **Self Injurious Behavior such as cutting, scratching, etc.**

Date of Symptom Onset (month/year): _____ ☐ This is an ongoing behavior ☐ Not a current behavior

☐ **Eating Disorder**

Date of Symptom Onset (month/year): _____ ☐ This is an ongoing behavior ☐ Not a current behavior

☐ **Autism Spectrum Disorder**

Date of diagnosis (month/year): _____ List diagnosis: _____

☐ **Seasonal Affective Disorder requiring placement in a country with adequate sunlight**

Date of diagnosis (month/year): _____ List diagnosis: _____

☐ **Alcoholism or other substance abuse**

Date of sobriety (month/year): _____ Drug(s) of choice: _____

Application Case ID:

☐ I have been sober for less than 3 years.

☐ I have been free from drug abuse for less than 5 years.

If you answered yes to any of the above diagnoses, please record the date of diagnosis and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.
- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

For the questions below, please select any condition for which you either have received mental health counseling within the past three years OR, even if you did not receive mental health counseling, you experienced a symptom in the past three years that lasted longer than two weeks and affected your ability to fully engage in daily activities.

☐ Mood/or Affect (e.g. Depression, Dysthymia, Adjustment Disorder with Depressed Mood)

☐ Issues such as Panic Attacks, Panic Disorder, Phobia, Obsessive Compulsive Disorder, Generalized Anxiety Disorder

☐ Anxiety Issues such as Post Traumatic Stress Disorder, Acute Stress Disorder, Adjustment Disorder with Anxious Mood

☐ Academic (for example: difficulty adjusting to college life, Attention Deficit/Hyperactivity Disorder, Learning Disorders)

☐ Personality Concerns (for example: Borderline Personality, Anger Management Problems, challenges maintaining good working relationships or strong social relationships with others)

☐ Substance use or abuse (for example: alcohol or drug related problems, including black outs, or heavy drinking patterns, or misuse of illegal or prescription drugs)

☐ Excessive Dieting or Excessive Exercise (for example: Anorexia, Bulimia, Binging and Purging)

☐ Any mental health symptom or diagnosed condition not previously listed

If you selected any of the above conditions, please indicate whether you received a diagnosis and what it was, record the prescribed medication and dosage, and prepare a personal statement responding to all of the bullet points below. (Submit along with the completed Health History Form)

Date of Diagnosis (month/year):_____

Medication, route, and dosage: _____

_____

- How does this condition affect your activities of daily living/work?
- What is your plan for managing any symptoms while serving with the Peace Corps?
- Describe your response to all treatments prescribed for this condition.

- Do you have any concerns related to this condition that may impact on your ability to serve 27 months with the Peace Corps? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

CLOSING QUESTIONS

If you believe that you will need any special medical support in connection with any of the conditions you have described in the application to serve as Peace Corps volunteer, please describe the support you may need. Determinations on requests will be made on a case by case basis_____

_____

_____

_____

THE FOLLOWING QUESTIONS REFER TO ANY CONDITIONS FOR WHICH YOU HAVE NOT ALREADY PROVIDED INFORMATION.

Do you have any chronic or active condition(s) for which you have not seen a medical professional in the past two years but for which you will require access to care during service for this condition? ☐ Y ☐ N

If yes, please name the condition and date (month/year) of diagnosis for this condition._____

_____

Have you had surgery in your lifetime for which you have not seen a medical professional in the past two years but for which you will require access to care during service for this specific surgical procedure? ☐ Y ☐ N

If yes, please name the date (month/year), type and reason for surgery._____

_____

_____

_____

Have you been hospitalized overnight in your lifetime for which you have not seen a medical professional in the past two years but for which you will require access to care during service for the condition that required hospitalization? ☐ Y ☐ N

If yes, please name the condition and date (month/year) of diagnosis for this condition._____

_____

_____

Application Case ID:

Have you sustained a traumatic injury (motor vehicle accident or sports injury for example) in your lifetime, for which you have not seen a medical professional in the past two years but for which you will require access to care during service specific for this injury? ☐ Y ☐ N

If yes, please name the condition and date (month/year) of evaluation for this condition._____

_____

_____

Do you have pain that is either ongoing or intermittent (once in awhile), for which you have not seen a medical professional in the past two years but for which you will require access to care specific for this pain? ☐ Y ☐ N

If yes, please name the condition and date (month/year) of evaluation for this condition._____

_____

_____

Do you have a condition that will require the use of medical equipment, either daily or as needed, should you accept an invitation to serve? (Please select all that apply even if documented elsewhere on this form)

☐ **Insulin Pump**

☐ **C-PAP Machine**

☐ **Compressive Device**

☐ **Wheelchair, cane, walker, crutches**

☐ **Hearing aid**

☐ **Orthotics**

☐ **Any medical device that requires the use of batteries of electricity for maintenance**