Health History Form

OMB No.: 0420-0510

Expiration Date: 00/00/0000

## Health History Introduction

The Peace Corps needs to assess your overall health status before you can be accepted to serve overseas. The health history is the first step in the medical review process, which will take about an hour to complete. Your signature at the end of the questionnaire certifies that you have answered all questions accurately and completely.

## A Medical History for International Placement

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

For this reason, the types of medical questions and the level of detail required are unlike other medical histories you might normally be asked.

The Applicant Medical Screening Process is thorough, and it is important for you to answer all questions accurately. On average, Peace Corps is able to medically clear more than 85% of all applicants.

## 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 - 0510). Do not return the completed form to this address.

## 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.**

**Medical Case Number:**

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: _____

OMB 0420-0510

## OPENING QUESTIONS

(CHECK BOX)Have you ever filled out a Health History Questionnaire for the Peace Corps before?

Year:

<<DATE FIELD>>

What is your birth sex?

Select: Male or Female or Other

Is your current gender identity the same as your birth sex?

YES or

NO, <<dropdown>> questions:

1. Have you received medical or mental health care related to your gender identity?
2. Do you require medications to support your identified gender? YES/NO
    a. These medications are listed in the medication section (Yes only)

How tall are you? (height in inches):

<<DESCRIPTION BOX>>

How much do you weigh? (weight in pounds):

<<DESCRIPTION BOX>>

(YES or NO) Have you had surgery in your lifetime?

If yes, <<DROPDOWN>>

Describe:

| Year | Procedure/Reason for Surgery | Location on Body | |
|---|---|---|---|
| | | | Delete |
| | | | |

Add a surgery

(CHECK BOX) I require visits to a health-care provider for a medical, mental health, and/or dental condition every three to four months or more frequently (medication refills, laboratory or diagnostic testing, medical or mental health, or dental follow-up, etc.).

Describe: <<DESCRIPTION BOX>>

## REPORT OF CURRENT MEDICATIONS

(CHECK BOX)Do you take any medications, including any regularly taken over-the-counter medications or herbal remedies?

Please list all medications you are currently taking. If you do not know the strength of a medication, answer "unknown."

***As you complete this questionnaire, make sure you report each health condition for which you take prescription medication.***

| Medication (Name): | Route: (oral, inhaled, injectable, topical) | Strength (e.g. 50mg): | Frequency | Condition being treated: | Start Date | End Date |
|---|---|---|---|---|---|---|
| | | | | | | |

(CHECK BOX) Are any of your listed medications injectable medications?

(CHECK BOX) Are any of your listed medications immunosuppressive medications for a chronic medical condition (including chronic steroids)?

(CHECKBOX) Are any of your listed medications blood thinners for a chronic medical condition?

<<Yes/No>> Do any of your listed medications require refrigeration?

Describe: <<DESCRIPTION BOX>>

## REPORT OF PHYSICAL ABILITIES

Peace Corps Volunteers serve in countries in conditions that may include remote locations with rugged terrain or urban sites that require climbing 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.

**Check all that apply: (If you mark "cannot," a description is required)**

<<Yes/No>> I can walk distances greater than two miles on rough or uneven terrain on a daily basis.

If No, Describe why not:

<<DESCRIPTION FIELD>>

<<Yes/No>>I can climb at least two flights of stairs carrying groceries or luggage without difficulty on a daily basis.

If No, Describe why not:

<<DESCRIPTION FIELD>>

<<YES/NO>>I can tolerate riding in a vehicle on rough roads on a daily basis.

If No, Describe why not:

<<DESCRIPTION FIELD>>

<<Yes/No>>I can hold a squat position for several minutes to use a squat commode or toilet.

If No, Describe why not:

<<DESCRIPTION FIELD>>

<<Yes/No>>I can independently lift or manage my luggage and other supplies during service (up to a weight of 50 pounds)?

If No, Describe why not:

<<DESCRIPTION FIELD>>

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

(CHECK BOX) Heat >90 degrees (CHECK BOX) Cold <20 degrees (CHECK BOX) Constant dampness (CHECK BOX) Constant dust

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

<<DESCRIPTION BOX>>

<<Yes (Yes I have)/No (No I do not have)>> I have a medical condition(s) that would prohibit me from living at high altitudes (more than 5,000 feet above sea level)

If Yes, Please describe the medical condition:

<<DESCRIPTION BOX>>

<<Yes (Yes I have)/No (No I do not have)>> I have limitations on my functional abilities to meet my activities of daily living.

If Yes, Describe the limitations on your functional abilities:

<<DESCRIPTION BOX>>

What kind of accommodations do you require?

<<DESCRIPTION BOX>>

<<Yes (Yes I use)/No (No I do not use) >> I require or use prosthetic device for any part of my body.

If Yes, What kind of prosthetic device do you require?

<<DESCRIPTION BOX>>

**ALLERGY**

**(Conditions of Allergic Response)**

**Life-Threatening Reactions**

**(Check Box) 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 drop in blood pressure.**

| Substance that caused a life-threatening allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add an another substance that caused a life-threatening allergic reaction

(Check Box) My reaction required an emergency room visit or hospitalization.

Date:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

**Allergy Shots**

**(Check Box) I currently receive allergy shots.**

Expected date of final treatment:

<<DATE FIELD>>

(Check Box) **In my lifetime, I have had an allergic reaction to one or more of the following: medication, food, animals, environment, insects or other allergens (See below for a list of conditions)**.

(Check Box) **I have had no symptoms of an allergic reaction or intolerance.**

Select all that apply

(Yes/No Check Box) **Allergy to 3 or more antibiotics**

| Please list the antibiotic medications that cause an allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add a medication

(Check Box) **Medication allergens** (dropdown)

(Check Box) **Sulfa allergy**

| Name of medication | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add a sulfa medication

(Check Box) **Penicillin allergy**

| Name of medication | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add a penicillin medication

(Check Box) **Tetracycline allergy**

| Name of medication | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add a tetracycline medication

(Check Box) **Other medication allergies not previously listed**

| Name of medication | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add a medication allergy not previously listed

(Check box) **Food allergens** (dropdown)

(Check Box) **Peanut allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Other nut allergy**

| Please list any other nut that causes an allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|

| | | | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add another nut for which you are allergic

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Shellfish allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Eggs or egg protein allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) I have been restricted from receiving certain vaccinations due to my egg allergy.

(Check Box) **Other food allergy**

| Please list any other food | Describe your reaction | Date of last reaction | |
|---|---|---|---|

| that causes an allergic reaction | | | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add another food that causes an allergic reaction

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Severe allergic reaction to animals (dropdown)**

(Check Box) **Cat allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Dog allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Other animal allergy (ies)**

| Please list any other animal that causes an allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add another animal that causes an allergic reaction

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Severe allergic reaction to insects (dropdown)**

(Check Box) **Bee, wasp, or other insect allergy**

| Please list the insect that causes an allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add another insect that causes an allergic reaction

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Severe allergic reaction to environmental allergens** (dropdown)

(Check Box) **Dust allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Mold allergy**

| | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Seasonal allergy (pollen, trees, etc.)**

| Please list any seasonal substance that causes a severe allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add a seasonal substance that causes a severe allergic reaction

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Other environmental allergy (ies) not previously listed**

| Please list any other environmental substance(s) that causes a severe allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add another environmental substance that causes a severe allergic reaction

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

(Check Box) **Other allergy (ies) not previously listed**

| Please list any other substance that causes an allergic reaction | Describe your reaction | Date of last reaction | |
|---|---|---|---|
| <<DESCRIPTION FIELD>> | <<DESCRIPTION FIELD>> | <<DATE FIELD>> | Delete |

Add another substance that causes an allergic reaction

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) It is recommended that I carry an EpiPen.

(Check Box) I have an inhaler to use during an allergic reaction.

(Check Box) My treatment requires a prescription medication on most days.

(Check Box) I use over-the-counter medication to treat my allergies.

## CARDIOVASCULAR

## (Conditions of the Heart or Blood Vessels)

**Have you ever had any of the following?**

**(CHECK BOX) Heart or Major Heart Vessel Surgery or Procedures**

Diagnosis: <<DROPDOWN: Coronary artery angioplasty and stents, Coronary artery bypass graft (CABG), Carotid artery endarterectomy, or other << textbox>>

Date of surgery or procedure:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Coronary Heart Disease**

Diagnosis: <<DROPDOWN: Carotid artery occlusion or stenosis, Angina pectoris, Heart attack or myocardial infarction (MI), Coronary artery disease (CAD), or other << textbox>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Congestive Heart Failure**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Cardiomyopathy**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Endocarditis**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Pericarditis**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Pulmonary Embolism**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Pacemaker**

Date of insertion:

<<DATE FIELD>>

Reason for pacemaker

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I am still being treated with a pacemaker.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Implantable Defibrillator**

Date of insertion:

<<DATE FIELD>>

Reason for implantable defibrillator

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I am still being treated with an implantable defibrillator.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Heart defect present since birth that requires specialized care**

Describe:

<<DESCRIPTION FIELD>>

**(CHECK BOX) Aneurysm**

Type of aneurysm: <<DROPDOWN: Abdominal or Thoracic or Aortic or other <<textbox>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Heart Irregularity or Heart Conduction Disorder**

Diagnosis: <<DROPDOWN: Atrial flutter, Atrial fibrillation, Heart/bundle branch block, Palpitations, Irregular rhythm, Tachycardia, Bradycardia, Wolff-Parkinson-White Syndrome, or other <<text box >>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Marfan's Syndrome**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Recurrent fainting, syncope, or loss of consciousness**

Diagnosis:

<<DESCRIPTION BOX>>

Date of last occurrence:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Stroke or stroke-like symptoms**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Heart valve or septal (hole in the heart) disorder**

Diagnosis: <<DROPDOWN: Aortic stenosis, Atrial septal defect (ASD), Ventricular septal defect (VSD), Heart murmurs, Mitral valve prolapse, Mitral valve regurgitation, Mitral valve stenosis, Patent ductus arteriosus (PDA), Pulmonary valve regurgitation, Pulmonary stenosis, Tricuspid

regurgitation (Insufficiency), Tricuspid stenosis, Aortic aneurysm, Patent foramen ovale (PFO), or other << textbox>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Are you currently taking a <u>blood thinning medication</u>, other than aspirin?**

Please explain:

<<DESCRIPTION BOX>>

(CHECK BOX) **I am 50 years of age or older.**

(CHECK BOX) **I have had an electrocardiogram in the last six months.**

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW.**

(CHECK BOX) In the **<u>past two years</u>**, I have seen a primary care physician or cardiologist for a heart or blood vessel condition or a medication refill (see below for a list of conditions).
(CHECK BOX) I have not seen a doctor in the **<u>past two years</u>** for any heart or blood vessel condition.

**Please check all conditions that apply.**

(CHECK BOX) **High blood pressure**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION FIELD>>

(CHECK BOX) **High cholesterol or high triglycerides**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION FIELD>>

(CHECK BOX) **Peripheral vascular disease**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION FIELD>>

(CHECK BOX) **Symptomatic varicose veins (painful and/or past history of varicose veins surgery)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION FIELD>>

(CHECK BOX) **Raynaud's syndrome**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I can only live in certain climates due to the severity of this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION FIELD>>

(CHECK BOX) **Any cardiac symptoms (such as fainting or chest pain), diagnosed condition, or cardiac surgery not previously listed**

(CHECK BOX) I was given a diagnosis for my symptoms.

Diagnosis:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) The condition causing my symptoms is not known and I do not have a diagnosis.

Describe symptoms:

<<DESCRIPTION FIELD>>

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION FIELD>>

## Dermatology

## (Conditions of the Skin)

**In my lifetime, I have had (please choose all that apply):**

<<CHECKBOX>> **Skin cancer (melanoma, basal cell carcinoma, squamous cell carcinoma, or other skin cancer)**

Diagnosis: <<DROPDOWN: Melanoma, basal cell tumor, squamous cell tumor, or other << text box>>

Date of most recent diagnosis:

<<DATE FIELD>>

Where was the lesion on your body?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require follow up, at least annually.

<<DESCRIPTION>>

<<CHECKBOX>> **Other skin lesion(s) (actinic keratosis, moles, or nevi or other pre-cancerous skin tumor or lesion)**

Diagnosis: <<DROPDOWN: Actinic keratosis, moles, nevi, or other << TEXT BOX>>

Date of diagnosis:

<<DATE FIELD>>

List location(s):

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require follow up, at least annually.

<<DESCRIPTION>>

<<CHECK BOX>> **Are you currently taking medication for a skin condition (such as steroids, oral isotretinoins [e.g. Absorica, Accutane, Amnesteem, Claravis, Myorisan, Zenatane], long-term anti-fungal medication, immunomodulators)?**

Please describe:

<<DESCRIPTION BOX>>

<<CHECKBOX>> **In the past two years, I have seen a primary care physician, surgeon, or dermatologist for a skin condition or medication refill (see list of conditions below).**

<<CHECKBOX>> **I have not seen a doctor in the past two years for any skin condition.**

**Please check all conditions that apply.**

<<CHECKBOX>> **Acne**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I have prescription medication for this condition.

NOTE: If undergoing treatment with an oral isotretinoin, applicant must be stable for two months post-treatment with documented normal laboratory studies prior to clearance for Peace Corps service.

<<CHECKBOX>> **Serious hair loss (alopecia) excluding male pattern baldness.**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

Is this caused by another medical condition? (CHECKBOX YES/NO)

If yes, please explain.

<<DESCRIPTION BOX>>

<<CHECKBOX>> I have prescription medication for this condition.

NOTE: The Peace Corps does not provide medication for hair loss for strictly cosmetic purposes.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Pilonidal cyst**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I currently have symptoms.

<<CHECKBOX>> I have had recurrent infected cysts.

Most recent episode:

<<DATE FIELD>>

<<CHECKBOX>> **Lipoma**

List location(s):

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Herpes zoster (shingles)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Rosacea**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Eczema**

Date of diagnosis:

<<DATE FIELD>>

Location and extent:

<<DESCRIPTION BOX>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I have prescription medication for this condition.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Psoriasis**

Date of diagnosis:

<<DATE FIELD>>

Location and extent:

<<DESCRIPTION BOX>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I have prescription medication for this condition.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Non-genital warts**

Date of diagnosis:

<<DATE FIELD>>

Location and extent:

<<DESCRIPTION BOX>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Genital warts**

Date of diagnosis:

<<DATE FIELD>>

Location and extent:

<<DESCRIPTION BOX>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I have prescription medication for this condition.

<<CHECKBOX>> I have had recurrent episodes.

Most recent episode:

<<DATE FIELD>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

<<CHECKBOX>> **Any skin symptom (such as a rash, itching, or dry skin), diagnosed condition, or skin surgery not previously listed.**

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I was given a diagnosis for my symptoms.

List diagnosis:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

<<CHECKBOX>> I do not know the name of condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<Date Field>>

Location and extent:

<<DESCRIPTION BOX>>

<<CHECKBOX>> I have prescription medication for this condition.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

**ENDOCRINOLOGY**

**(Diabetes or conditions of the Pituitary, Thyroid, Parathyroid, and Adrenal Glands)**

**Have you had any of these conditions in your lifetime?**

**(Check all that apply.)**

**(Check box) Cancer or carcinoma of the endocrine system (thyroid, pituitary gland, parathyroid glands, thymus, pancreas, or adrenal glands)**

Diagnosis: <<DROPDOWN>> Thyroid, pituitary gland, parathyroid glands, thymus, pancreas, adrenal glands, other with text box

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Non-cancerous tumor affecting your endocrine system (thyroid, pituitary gland, parathyroid glands, thymus, pancreas, or adrenal glands)**

Diagnosis: <<DROPDOWN>> Thyroid, pituitary gland, parathyroid glands, thymus, pancreas, adrenal glands, other with text box

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Disease or condition of the pituitary gland**

Diagnosis:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Disease or condition of the adrenal gland (pheochromocytoma, congenital adrenal hyperplasia, Cushing disease, Addison's disease)**

Diagnosis: <<DROPDOWN>> Pheochromocytoma, congenital adrenal hyperplasia, Cushing disease, Addison's disease, or other with text box

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Diabetes mellitus, Type 1**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I currently manage this condition with an insulin pump.

(Check box) **Diabetes mellitus, Type 2**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I require injectable (by a shot) medication either daily or as needed for this condition.

(Check box) **Disease of the thyroid gland (hypothyroidism, hyperthyroidism, Hashimoto's disease, Grave's disease, thyroid storm)**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Disease of the parathyroid gland (hypoparathyroid or hyperparathyroid)**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Osteoporosis**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Other hormone disorder (growth or reproductive or other)**

Diagnosis: <<DROPDOWN>> Growth, reproductive, other with text box

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition. *Note: Do not include oral contraceptives.*

Describe:

<<DESCRIPTION BOX>>

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(Check box) In the **past two years,** I have seen a primary care physician, endocrinologist, or other specialist for a condition of the endocrine system (e.g., diabetes or conditions of the pituitary, thyroid, parathyroid, or adrenal glands) or a medication refill (see below for a list of conditions.)
(Check box) I have not seen a doctor in the **past two years** for any condition of the endocrine system.

**Check all conditions or symptoms that apply**

(Check box) **Glucose disorder, other than diabetes mellitus, (e.g., hypoglycemia or pre-diabetes)**

Diagnosis <<dropdown >> Hypoglycemia, pre-diabetes, or other with text

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

-(Check box) **Hyperthyroidism or Grave's disease**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Hypothyroidism (underactive thyroid)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

-(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

-(Check box) **Acromegaly (growth hormone secreting pituitary tumor)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Prolactin-secreting pituitary tumor (abnormal milk production in women)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

<<DESCRIPTION BOX>>

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Non-functioning (no production of hormones) pituitary tumor**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Pheochromocytoma**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Gout**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Reproductive hormone abnormalities (amenorrhea, testosterone/estrogen problems, polycystic ovary syndrome, or other)**

Diagnosis: <<DROPDOWN>> amenorrhea, testosterone/estrogen problems, polycystic ovary syndrome, or other with text box

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **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 two years.**

(Check box) I was given a diagnosis for my symptoms.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I do not know the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**EAR, NOSE, and THROAT**

**(Conditions of the Ear, Nose, and Throat)**

## Have you ever had any of the following?

(CHECK BOX) **I have no issues with hearing**

(CHECK BOX) **I am hard of hearing**

Please select the status that applies to you

<< DROPDOWN>>

(CHECK BOX) **I am hard of hearing and I use spoken English as my primary means of communication**.

(CHECK BOX) **I am hard of hearing and I use American Sign Language as my primary means of communication.**

(CHECK BOX) **I am hard of hearing and I use a combination of spoken English and American Sign Language as my means of communication.**

When and how did hearing loss occur?

<<DESCRIPTION BOX>>

Ears affected:

Select: Left or Right or Both

(CHECK BOX) I have had a hearing evaluation (such as audiometry).

(CHECK BOX) I require the daily use of a hearing aid(s).

List type, date of purchase, manufacturer, model number, and replacement plan, if any.

<<DESCRIPTION BOX>>

(CHECK BOX) I only require use of a hearing aid(s) in certain situations.

Please provide examples:

<<DESCRIPTION BOX>>

(CHECK BOX) Electricity is required for charging my hearing aid(s) or a dry box.

(CHECK BOX) My hearing aid(s) may need to be replaced in the next three years.

Date of expected future replacement and what is your plan?

<<DESCRIPTION FIELD>>

(CHECK BOX) I currently use support modalities and/or assistive technology to manage daily activities and work.

<<DESCRIPTION FIELD>>

(CHECK BOX) **I am deaf and** (Please select the status that applies to you)

1. **Use American Sign Language as my primary means of communication.**

   When and how did hearing loss occur?

   <<DESCRIPTION BOX>>

2. **Use both spoken English and American Sign Language as my means of communication.**

   When and how did hearing loss occur?

   <<DESCRIPTION BOX>>

3. **Use spoken English as my primary means of communication.**

   When and how did hearing loss occur?

   <<DESCRIPTION BOX>>

4. I have cochlear implants.

   Date of cochlear implant surgery(ies).

   <<DATE FIELD>>

(CHECK BOX) I only require use of a cochlear implant sound processor(s) in certain situations rather than daily.

Please provide examples:

<<DESCRIPTION BOX>>

Date of last mapping for cochlear implant(s)

<<DATE FIELD>>

(CHECK BOX) My cochlear implant will require mapping during my service.

Describe when and how often:

<<DESCRIPTION BOX>>

(CHECK BOX) Electricity is required for charging my cochlear implant.

(CHECK BOX) I currently use support modalities and/or assistive technology to manage daily activities and work.

<<DESCRIPTION FIELD>>

**In my lifetime I have/had:**

(CHECK BOX) **Cancer or malignancy of the throat, mouth, tongue, salivary glands, neck**

Location: <<DROPDOWN: Throat, Mouth, Tongue, Salivary Glands, Neck, other <<textbox>>

Date of diagnosis

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require follow up, at least annually.

Describe:

<<DESCRIPTION>>

(CHECK BOX)**Other growths (non-cancerous) associated with the ear, nose, throat, mouth, tongue, vocal cords, salivary glands, or neck (e.g., acoustic neuroma, cholesteatoma)**

Diagnosis: List with multi-select checkbox

<<Checkbox>> Acoustic neuroma

<<Checkbox>> Cholesteatoma

<<Checkbox>> Other (Please describe)

<<DESCRIPTION BOX>>

Date of diagnosis

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>

<<CHECKBOX>> I require follow up, at least annually.

<<DESCRIPTION>>

(CHECK BOX) **Ear, nose, or throat surgery (ear, nose, mouth, tongue, throat, salivary glands, vocal cords, or neck)**

Describe:

<<DESCRIPTION BOX>>

Date of surgery

<<DATE FIELD>> (DATE JUST THE YEAR)

<<CHECKBOX>> I require follow up, at least annually.

<<DESCRIPTION>>

(CHECK BOX) **Sleep apnea**

Date of diagnosis

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(CHECK BOX) In the **past two years**, I have seen a primary care physician or ear, nose, and throat specialist for an ear, nose, and throat condition or a medication refill (see below for a list of conditions).

(CHECK BOX) I have not seen a doctor in the **past two years** for any ear, nose, and throat condition**.**

**Please check all conditions that apply.**

(CHECK BOX) **Recurrent throat infections (strep, thrush, oral ulcers of mouth, tongue or throat)**

Treatment plan:

<<DESCRIPTION BOX>>

(CHECK BOX) **Vocal cord disorder**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

<<DESCRIPTION BOX>>

(CHECK BOX) **Vertigo (dizziness)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe: <<DESCRIPTION BOX>>

(CHECK BOX) **Tinnitus (ringing in the ear)**

Date of diagnosis: <<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe: <<DESCRIPTION BOX>>

(CHECK BOX) **Chronic ear infection**

Date of diagnosis: <<DATE FIELD>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe: <<DESCRIPTION BOX>>

(CHECK BOX) **Chronic sinusitis**

Date of diagnosis: <<DATE FIELD>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe: <<DESCRIPTION BOX>>

(CHECK BOX) **Chronic tonsillitis**

Date of diagnosis: <<DATE FIELD>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe: <<DESCRIPTION BOX>>

(CHECK BOX) **Recurrent nose bleeds (absent trauma)**

Date of diagnosis: <<DATE FIELD>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description: <<DESCRIPTION BOX>>

(CHECK BOX) **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 two years.**

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I was given a diagnosis for my symptoms.

List diagnosis

<<DESCRIPTION FIELD>>

Date: << DATE FIELD>>

(CHECK BOX) I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms

<<DATE FIELD>>

<<CHECKBOX>> I currently have moderate to severe symptoms that affect my daily life.

Describe symptoms

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require special medical treatment for this condition.

Describe: <<DESCRIPTION BOX>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe: <<DESCRIPTION BOX>>

**GASTROENTEROLOGY**

**(Conditions of the Colon, Stomach, Pancreas, and Liver)**

**In my lifetime I have/had:**

(CHECK BOX) **Cancer of the gastrointestinal tract (esophagus, stomach, duodenum, liver, gall bladder, pancreas, appendix, small intestines, colon, rectum, or mesentery)**

Actual diagnosis (check all that apply):

<<DROPDOWN>> Esophagus, stomach, duodenum, liver, gall bladder, pancreas, appendix, small intestines, colon, rectum, mesentery, or other with text box

Date of most recent diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Cirrhosis of the liver**

Date of diagnosis

<<DATE FIELD>>

**(Check box) Hepatitis (inflammation of the liver)**

**Diagnosis (check at least one box below)**

<<DROPDOWN:

Hepatitis A

Hepatitis B

Hepatitis C

Unknown

Date of diagnosis:

<<DATE FIELD>>

(Check box) I have prescription medication for this condition.

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Any other diseases of liver or abnormal liver tests (e.g., Gilbert disease, fatty liver, alcohol-related liver injury, sarcoid liver, malaria, parasitic disease, or gall bladder-related issues)**

**Diagnosis**

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Gastrointestinal surgery (esophagus, stomach, gall bladder, intestine, intestinal wall, anus, or rectum)**

**Diagnosis:**

<<DESCRIPTION BOX>>

Date of most recent surgery:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Ulcerative colitis, Crohn's, or any other inflammatory bowel disease**

Diagnosis (check at least one box below):

<<DROPDOWN: Ulcerative colitis, Crohn's, or other with text box

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have had treatment with immunosuppressive medication for this condition.

(CHECK BOX) **I currently have a colostomy, ileostomy, or any other surgical repair of the colon**

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Recurrent pancreatitis**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **A history of stricture, obstruction, abscess, fistula, or fissure (i.e., anal fissure)**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Gastrointestinal bleeding (vomiting blood or blood in stools) (e.g., gastritis, peptic ulcer disease, esophageal varices/tears, hemorrhoids, or other with text box)**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Lactose intolerance**

(CHECK BOX) I was diagnosed a health-care provider with lactose intolerance.

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **Gluten intolerance**

(CHECK BOX) I was diagnosed by a health-care provider with gluten intolerance.

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **Celiac disease**

Date of diagnosis:

<<DATE FIELD>>

**PLEASE CHECK AT LEAST ONE OF THE OPTIONS BELOW**

(CHECK BOX) I am under 50 years of age
(CHECK BOX) I am 50 years of age or older

**PLEASE CHECK AT LEAST ONE OF THE FOLLOWING BOXES. CHECK ALL THAT APPLY.**

(CHECK BOX) Colonoscopy (within 10 years)

(CHECK BOX) My test was abnormal and required further follow-up testing.

(CHECK BOX) Flexible sigmoidoscopy (within 10 years) and a fecal immunochemical test (FIT) (within one year)

(CHECK BOX) My test was abnormal and required further follow-up testing.

(CHECK BOX) Fecal immunochemical test or high-sensitivity gFOBT (FIT or iFOBT) (within one year)

(CHECK BOX) My test was abnormal and required further follow-up testing.

(CHECK BOX) I have not had any of the tests listed above within the defined time frames.

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(CHECK BOX) In the **past two years,** I have seen a primary care physician or gastroenterologist for a colon, stomach, pancreas, or liver condition or a medication refill (see below for a list of conditions).
(CHECK BOX) I have not seen a doctor in the **past two years** for any colon, stomach, pancreas, or liver condition.

**Please check all conditions that apply**

(CHECK BOX) **Acute pancreatitis**

Date of diagnosis:

<<DATE FIELD>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Irritable bowel syndrome**

Date of diagnosis:

<<DATE FIELD>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

-(CHECK BOX) **Inguinal hernia (protrusion of abdominal contents into the lower abdomen)**

Date of diagnosis: <<DATE FIELD>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I had surgery due to this condition.

Date of surgical repair

<<DATE FIELD>>

(CHECK BOX) Not surgically repaired

(CHECK BOX) **Gastroesophageal reflux disease (heartburn)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) **Diverticulitis (inflammation of the lining of the colon)**

Date of diagnosis:

<<DATE FIELD>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Peptic ulcer (a mucosal break in the stomach or small intestine)**

Date of diagnosis:

<<DATE FIELD>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Gastritis (inflammation of the mucosa of the stomach)**

Date of diagnosis:

<<DATE FIELD>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Internal or external hemorrhoids**

Date of diagnosis: <<DATE FIELD>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I had surgery due to this condition.

(CHECK BOX) **Chronic or recurrent abdominal pain (check only if you have not already reported this condition above)**

(CHECK BOX) I was given a diagnosis for my symptoms.

Describe:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Parasite disease that affected my gastrointestinal tract**

Date of diagnosis: <<DATE FIELD>>

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Any other intestinal, stomach, pancreas, or liver condition (including surgeries) not previously listed for which you have sought medical attention in the past two years**.

(CHECK BOX) I was given a diagnosis for my symptoms.

Describe:

<<DESCRIPTION BOX>>

Date of diagnosis: <<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

## Gynecology

## (Conditions of the Female Breast and Female Reproductive System)

**In my lifetime, I have had a uterus, ovaries, or female breasts. Yes or No**

**If yes:**

**Have you had any of these conditions in your lifetime? (Check all that apply)**

(CHECK BOX) **Breast cancer**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Uterine cancer or endometrial cancer**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Ovarian cancer**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX)I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Vaginal or vulvar cancer**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX)** I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Other gynecological cancer, not previously specified**

Date of diagnosis:

<<DATE FIELD>>

Diagnosis:

<<DESCRIPTION FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) History of gynecological/breast surgeries**

Type of surgery:

Describe:

<<DESCRIPTION FIELD>>

***NOTE:*** *The Peace Corps offers routine mammogram screenings for women who are 50 years of age or older during their service. The Peace Corps follow United States Preventative Services Task Force recommendations of routine screening mammogram every two years, unless there is a clinical indication for more frequent screening. Note: Not all countries have the capabilities to provide routine screening mammograms.*

**You must check an option below:**

**(CHECK BOX)** 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.

**(CHECK BOX)** 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 require site placement where routine mammogram screenings is provided.

**(CHECK BOX)** I will be 50 years of age or younger **during the time of my Peace Corps service.**

**(CHECK BOX) I am over 50 and I have had a mammogram.**

Date of last mammogram:

<<DATE FIELD>>

Result of mammogram:

**(CHECK BOX)** Normal

**(CHECK BOX)** Abnormal

**(CHECK BOX) I am under 50 and I have had a mammogram or sonogram.**

Date of last mammogram or sonogram:

<<DATE FIELD>>

Result of mammogram or sonogram:

**(CHECK BOX)** Normal

**(CHECK BOX)** Abnormal

**Please check the option below that describes your <u>most recent</u> Pap result.**

(CHECK BOX) Normal

Date of last Pap: <<DATE FIELD>>

(CHECK BOX) Abnormal

Date of last Pap: <<DATE FIELD>>

(CHECK BOX)) Never had a Pap

***<u>Check all that apply:</u>***

(CHECK BOX) **I have had an abnormal Pap in the past three years.**

(CHECK BOX) **I no longer have a cervix and do not need Pap screenings.**

Diagnosis:

<<DESCRIPTION BOX>>

Date of surgery:

**<<DATE FIELD>>**

**(CHECK BOX) I have or have had breast implants.**

Type of implant:

<<DESCRIPTION BOX>>

Date of surgery:

<<DATE FIELD>>

(CHECK BOX) **I am currently on or considering a type of birth control.**

*<u>Note:</u> The Peace Corps will provide the generic equivalents for most medications. Some methods of contraception are not available in many countries. These are noted below*.

(CHECK BOX) **Oral contraceptive**

(CHECK BOX) **Depo-Provera injections**

(CHECK BOX) **NuvaRing**

*Note: It is unlikely the Peace Corps will provide this method of contraception.*

(CHECK BOX) **Cervical cap**

*Note: It is unlikely the Peace Corps will provide this method of contraception.*

(CHECK BOX) **Diaphragm**

*Note: It is unlikely the Peace Corps will provide this method of contraception.*

(CHECK BOX) **Intrauterine device (IUD)**

Type and duration:

<<DESCRIPTION BOX>>

Date of insertion:

Note: If you are considering an IUD but do not yet have one, please use today's date.

<<DATE FIELD>>

*Note: Not all countries will be able to replace an IUD. Therefore, you will need to ensure that your IUD will not expire during your service.*

(CHECK BOX) **Implanted contraception (Nexplanon)**

Date of insertion:

<<DATE FIELD>>

Type and duration:

<<DESCRIPTION BOX>>

*Note: The Peace Corps will not replace contraceptive implants and there may not be an in-country provider who can remove this implant during your service. Therefore, you will need to ensure that your contraceptive implant will not expire during your service period, or has been removed or replaced prior to the start of your service.*

**(CHECK BOX) Birth control patch**

Date:

<<DATE FIELD>>

Name of patch

<<DESCRIPTION BOX>>

*Note: It is unlikely the Peace Corps will provide this method of birth control.*

**(CHECK BOX) Other**

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW:**

- Except for routine Pap screenings, 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 or a medication refill (See below for a list of conditions).
- I have not seen a doctor in the **past two years** for any condition of the female breast or female reproductive system.

**Please check all that apply**

**(CHECK BOX) Abnormal menstrual cycles (such as no bleeding, infrequent bleeding, heavy or painful bleeding)**

Diagnosis <<DROPDOWN): **Heavy; Absent; Painful; Irregular; other <<TEXT BOX>>**

(CHECK BOX) I have been given a diagnosis for this condition.

Diagnosis:

<<DESCRIPTION BOX>>

(CHECK BOX)The cause of my condition is known.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX)The cause of my condition is not known.

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX)I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Breast lump, solid breast mass, or fibrocystic breast**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Polycystic ovarian disease**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX)I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Ovarian cyst(s)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Endometriosis (uterine lining growing outside of the uterus)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Endometrial hyperplasia (excessive proliferation of the uterine lining)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Infected Bartholin cysts**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Genital herpes**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Genital ulcers**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Genital warts**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Fibroids**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Any gynecological symptom, diagnosed condition, or gynecological surgery not previously listed for which you have sought medical attention in the past two years (such as ectopic pregnancy, pelvic mass, uterine prolapse, uterine fibroids), excluding easily treated sexually transmitted diseases.**

Diagnosis:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX)I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition. **Do NOT check this box for regular visits to the doctor for routine Pap or mammogram visits.**

Describe:

<<DESCRIPTION BOX>>

## HEMATOLOGY

## (Conditions of the Blood)

**Have you had any of these conditions in your lifetime? (Check all that apply)**

(CHECK BOX) **Cancer related to the blood, circulatory system, lymphatic system (e.g., leukemia, lymphoma, or multiple myeloma)**

Diagnosis:

<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Bleeding or clotting disorder (e.g., deep vein thrombosis)**

Diagnosis:

<DESCRIPTION FIELD>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Hemophilia**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **My spleen has been surgically removed or is non-functioning.**

(CHECK BOX) Diagnosis (reason for removal)

<<DESCRIPTION BOX>>

Date of surgery:

<<DATE FIELD>>

(CHECK BOX) Diagnosis (reason for non-functioning)

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Essential (primary) thrombocytopenia**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Polycythemia vera (high red blood cell count)**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Myelofibrosis**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Sickle cell disease or sickle cell trait**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Thalassemia or thalassemia trait**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Hemoglobin C**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Hemochromatosis**

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) Aplastic anemia (decreased stem cell production)**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX)I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Hemolytic anemia (breakdown of red blood cells to a disease process)**

**Select Diagnosis:**

**(CHECK BOX) Auto-immune hemolytic anemia**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Hereditary hemolytic anemia**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition?

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Other hemolytic anemia**

(CHECK BOX) I was given a diagnosis for my symptoms.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

**(CHECK BOX) I do not know the name of the condition my symptoms or I have not been given a diagnosis.**

Date of initial symptoms:

<<DATE FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition?

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Any other blood disorder**

Diagnosis:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

- In the **past two years**, I have seen a primary care physician or hematologist for a blood condition or a medication refill (See below for a list of conditions).
- I have not seen a doctor in the **past two years** for any blood condition.

**Please check all conditions that apply.**

**(CHECK BOX) Iron deficiency anemia**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition?

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Vitamin B-12 or folate deficiency (megaloblastic/pernicious anemia)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition?

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Anemia caused by another condition (such as kidney disease)**

(CHECK BOX) I was given a diagnosis for my symptoms.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Anemia caused by blood loss (e.g., heavy menses, bleeding ulcer)**

Date of diagnosis:

<<DATE FIELD>>

How do you currently manage this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) A bleeding problem due to a specific medication**

Date of diagnosis:

<<DATE FIELD>>

Medication(s) causing bleeding problem:

<<DESCRIPTION BOX>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I required a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

**(CHECK BOX) Anemia**

Diagnosis:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIELD>>

Date of initial symptoms:

<<DATE FIELD>>

(CHECK BOX)I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I required a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

(CHECK BOX) **Any other symptom, diagnosed condition, or surgery of the blood or lymphatic system not previously listed for which you have sought medical attention in the past two years.**

(CHECK BOX) I was given a diagnosis for my symptoms.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I require prescription medication daily for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Description:

<<DESCRIPTION BOX>>

**INFECTIOUS DISEASE**

**(Conditions of Infectious Process)**

**In my lifetime I have been diagnosed with:**

**(Check box) Human immunodeficiency virus (HIV)**

Date of diagnosis:

<<DATE FIELD>>

**(Check box) Hepatitis (inflammation of the liver)**

**Actual diagnosis (check at least one box below)**

<<DROPDOWN:

Hepatitis A

Hepatitis B

Hepatitis C

Unknown

Date of diagnosis:

<<DATE FIELD>>

(Check box) I have prescription medication for this condition.

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Latent tuberculosis infection (positive skin test or positive blood test)**

**(Check box) Active tuberculosis disease**

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(Check box) In the **past two years,** I have seen a primary care physician or infectious disease specialist for an infectious disease or a medication refill (see below for a list of conditions).
(Check box) I have not seen a doctor in the **past two years** for any infectious disease.

**Check all conditions that apply**

(Check box) Diagnosis: **Have you had treatment for any sexually transmitted infection in the last two years.**

(Check box) **Syphilis**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Chancroid**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Genital warts (condyloma acuminata)**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Herpes**

Location: <<DROPDOWN: Oral, Genital, Anal>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>>

(Check box) **Shingles**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Chronic, frequent, or recurrent bacterial, fungal, viral infection, including thrush**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Any other infectious disease condition or symptom (e.g., dengue, Lyme, malaria, Zika, amoeba, giardia) or any viral syndromes (e.g., mononucleosis, Epstein Barr virus, cytomegalovirus) not previously listed for which you have sought medical attention in the past two years (does not include self-limiting conditions such as a cold, flu, or simple infections)**

**Diagnosis (check one box below)**

(Check box) I was given a diagnosis for my symptoms.

Describe:

<<DESCRIPTION BOX>>

(Check box) I don't know the name of the condition causing my symptoms or I have not been given a diagnosis.

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up due to this condition.

Describe:

<<DESCRIPTION BOX>>

**MENTAL HEALTH**
**(Conditions of Mental Health)**

**Medication:**

I am currently taking or have taken in the past four years medication related to mental health concerns (e.g., depression, anxiety, ADHD, etc.) (Yes or No)

(*If yes to above*)
Are you still currently taking any medications? (Yes or No)

*(If yes to above)*
I have had a change in my medication regimen (type of medication, dose, frequency, etc.) in the past 12 months. (Yes or No)

*(If yes to above)*
I currently take three or more medications (including as-needed medication) related to my mental health concerns (e.g. depression, anxiety, ADHD, etc.). (Yes or No)

**In my LIFETIME, I have been evaluated or treated (including talk-therapy and/or medication) for the following:**

Bipolar spectrum disorder (bipolar I, bipolar II, etc.) (Yes or No)
Evaluation date or date treatment started:

Schizophrenia or a related disorder (schizoaffective disorder, brief psychotic episode, etc.) (Yes or No)
Evaluation date or date treatment started:

Dissociation-related conditions (dissociative identity disorder, dissociative amnesia, etc.) (Yes or No)
Evaluation date or date treatment started:

Eating disorder or related behavior (anorexia, bulimia, binge eating disorder, etc.) (Yes or No)
Evaluation date or date treatment started:

Alcohol or substance-related concern (marijuana use disorder, alcohol use disorder—abuse or dependence, etc.) (Yes or No)
Evaluation date or date treatment started:
Do you regularly attend support meetings in person or online? (Yes or No)

Neurodevelopmental disorder (ADHD, learning disorder, autism spectrum disorder, etc.) (Yes or No)

Please check all that apply (at least one MUST be selected)

I take or have taken in the past 12 months an amphetamine-type medication, such as Adderal, Dexadrine.

I take or have taken in the past 12 months an amphetamine-type medication, such as Vyvanse.

I take or have taken in the past 12 months a stimulant-type medication, such as Ritalin, Concerta, Focalin.

I take or have taken in the past 12 months an antidepressant-type medication, such as Strattera, for my neurodevelopmental disorder.

No medication treatment.

I require or have required in the past three years academic support (such as an individual education plan) or other support to learn or work. (Yes or No)

I have am currently in or have required talk-therapy or counseling in the past for my neurodevelopmental disorder. (Yes or No)

Personality or conduct disorder (borderline personality disorder, oppositional defiant disorder, antisocial personality disorder, etc.) (Yes or No)

Evaluation date or date treatment started:

**In your LIFETIME, have you ever experienced:**

Self-injurious behavior (cutting, scratching, burning, etc.) (Yes or No)

Did you receive treatment (including talk-therapy or medication) for this concern? (Yes or No)

Suicidal thoughts, gestures, or an attempt to commit suicide (Yes or No)

Did you receive treatment (including talk-therapy or medication) for this concern? (Yes or No)

A hospitalization for mental health concerns/symptoms (related to suicidal ideation, psychosis, mania, substance abuse, etc.) (Yes or No)

Most recent hospitalization: Start Date:

Discharge Date:

A partial hospital program, an intensive outpatient program, or a rehabilitation program for mental health concerns/symptoms (related to suicidal ideation, psychosis, mania, substance abuse, etc.) (Yes or No)

Date(s):

**In the PAST FOUR YEARS, I have been evaluated or treated (including talk-therapy and/or medication) for the following:**

Depression or a related condition (major depressive disorder, persistent depressive disorder, etc.) (Yes or No)
Evaluation date or date treatment started:

Anxiety or a related condition (generalized anxiety disorder, panic disorder, etc.) (Yes or No)
Evaluation date or date treatment started:

Obsessive or compulsive-related concerns (obsessive-compulsive disorder, body dysmorphic disorder, etc.) (Yes or No)
Evaluation date or date treatment started:

Trauma or extreme stressor-related concerns (post-traumatic stress disorder, acute stress disorder, adjustment disorder with depression and/or anxiety, etc.) (Yes or No)
Evaluation date or date treatment started:

Sleep-related concerns (insomnia, hypersomnia, etc.) (Yes or No)
Evaluation date or date treatment started:

Pain or other somatic concern (somatization disorder, conversion disorder, etc.) (Yes or No)
Evaluation date or date treatment started:

Brain injury, memory loss, or other neurocognitive-related concerns (traumatic brain injury, Alzheimer's disease, etc.) (Yes or No)
Evaluation date or date treatment started:

Any other mental health-related concern not indicated in any of the fields above. (Yes or No)
Evaluation date or date treatment started:

**CURRENTLY or in the past 12 MONTHS I have:**

Seen a psychologist, social worker, counselor, therapist, or some other mental health professional for talk-therapy or counseling for a concern that has not already been identified on this form or in which my treatment did not/does not include a formal diagnosis. (Yes or No)
Date of last session:

Experienced persistent emotional distress or symptoms related to my mental health for which I have not yet sought care. (Yes or No)

**Musculoskeletal**

**(Conditions of the Muscles, Bones, Tendons, and Ligaments)**

(Check Box) **I have had cancer of the bone or muscle.**

Location:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check Box) I am currently being treated for this condition.

<<DESCRIPTION BOX>>

(Check Box) **I have a history of non-cancerous bone tumors or other diseases of the bone (Paget's disease, fibrous dysplasia)**

Location:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

-(Check Box) I am currently being treated for this condition.

<<DESCRIPTION BOX>>

(Check Box) **I have had orthopedic surgery in my lifetime and hardware (e.g.: pins, rods, joint replacement) was left in place.**

Describe the type of surgery(ies), reason for surgery(ies), and what hardware was left in place.

<<DESCRIPTION BOX>>

Date of most recent surgery:

<<DATE FIELD>>

(Check Box) I am currently being treated for this condition.

<<DESCRIPTION BOX>>

(Check Box) **I have functional limitation(s) or restriction(s) related to conditions of the muscle, bone, tendon, or ligament condition** *(Note to applicant: be sure you have selected the related diagnosis and/or associated condition)*

Describe:

<<DESCRIPTION BOX>>

(Check Box) I require medical equipment (brace, mobility assistive devices)

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(Check Box) 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) for a condition of the muscle, bone, tendon, or ligament or a medication refill (see below for a list of conditions).
(Check Box) I have not seen a doctor in the past two years for any condition of the muscle, bone tendon, or ligament.

**Please check all conditions that apply.**

(Check box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the back or spine**

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the neck**

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the skull**

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the knee**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular basis or intermittent basis), or medical care sought for any reason, in relation to the shoulder**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the hand or wrist**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

-(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the hip or pelvis**

Location:

- Left

- Right
- Both

(CHECK BOX) I was given a diagnosis.

Describe:

<<DESCRIPTION BOX>>

Date of diagnosis: <<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

<<DESCRIPTION>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the foot or ankle**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Describe:

<<DESCRIPTION BOX>>

Date of diagnosis: <<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

<<DESCRIPTION>>

(Check Box) **Any injury, surgery, or pain (on a regular basis), or medical care sought for any reason, in relation to the elbow**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Describe:

<<DESCRIPTION BOX>>

Date of diagnosis: <<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

<<DESCRIPTION>>

(Check Box) **Any injury, surgery, or pain (on a regular basis), or medical care sought for any reason, in relation to the arm**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the leg**

Location:

- Left
- Right
- Both

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the fingers**

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to the toes**

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Any injury, surgery, or pain (on a regular or intermittent basis), or medical care sought for any reason, in relation to any other muscle, bone, tendon, or ligament**

(CHECK BOX) I was given a diagnosis.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I do not know the name of the condition or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

(Check Box) I had surgery for this condition.

Date of surgery:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Osteoporosis (decreased bone mass with increased risk for the bone fracture)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication for this condition.

(Check Box) I have had a fracture in my lifetime due to this condition.

Date(s), location(s) of fracture:

<<DESCRIPTION BOX>>

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Osteopenia (low bone mass)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

-(Check Box) I have had a fracture in my lifetime due to this condition.

Date(s), location(s) of fracture:

<<DESCRIPTION BOX>>

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Degenerative Disc Disease (changes to the spinal discs)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check box) I have taken steroid or epidural injections.

Most recent:

<<DATE FIELD>>

Frequency:

<<DESCRIPTION FIELD>>

(Check Box) I sometimes experience numbness or pain in my leg or arm because of compressed nerve in my neck or back.

(Check Box) I have had a fracture in my lifetime due to this condition.

Date(s), location(s) of fracture:

<<DESCRIPTION BOX>>

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Degenerative Joint Disease (osteoarthritis)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) I have taken steroid or epidural injections.

Most recent:

<<DATE FIELD>>

Frequency:

<<DESCRIPTION FIELD>>

(Check Box) I sometimes experience numbness or pain in my leg or arm because of a compressed nerve in my neck or back.

-(Check Box) I have had a fracture in my lifetime due to this condition.

Date(s), location(s) of fracture:

<<DESCRIPTION BOX>>

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check Box) **Scoliosis (curvature of the spine)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) **Kyphosis (bowing of the spine)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require prescription medication daily for this condition.

(Check Box) **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 two years.**

Date of diagnosis:

<<DATE FIELD>>

(Check Box) I was given a diagnosis for my symptom(s).

Date of diagnosis:

<<DATE FIELD>>

Describe:

<<DESCRIPTION FIELD>>

(Check Box) I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(Check Box) I require medication daily for this condition.

(Check Box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**Neurology**

**(**Conditions of the Brain or Nervous System)

***In my lifetime,* I have had:**

**(Check box) A tumor (cancerous or non-cancerous) of the brain or spinal cord**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Any surgery of the brain or spinal cord**

Date of diagnosis:

<<DATE FIELD>>

Location:

<<DESCRIPTION FIELD>>

Reason:

<<DESCRIPTION BOX>>

**(Check box) Conditions involving blood vessels in your brain (such as brain aneurysm, cerebral vascular accident, stroke-like symptom, transient ischemic attack)**

Diagnosis:

<<DROPDOWN>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I had surgery or treatment for this condition.

Date of surgery or treatment:

<<DATE FIELD>>

**(Check box) Surgery and placement of a ventricular shunt**

Diagnosis:

<<DROPDOWN>>

Date of diagnosis:

<<DATE FIELD>>

Date of surgery:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) A seizure, seizure disorder, or epilepsy (other than a seizure as a baby caused by high fever)**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

Date of most recent seizure:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Any neuromuscular disorder, motor abnormality, or movement disorder (including tics), that affects your ability to function (such as amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, myasthenia gravis, cerebral palsy, muscular dystrophy, post-polio syndrome, Tourette's syndrome, tremors)**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Any diagnosis/treatment for concussion, head trauma, or brain injury**

Description:

<<DESCRIPTION FIELD>>

Date of diagnosis:

<<DATE FIFELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Sleep-related condition (such as narcolepsy, insomnia, restless leg syndrome, sleep walking)**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(Check box)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 or a medication refill (see below for a list of conditions).

(Check box) I have not seen a doctor in the **past two years** for any condition of the brain or nervous system.

(Check box) **Have you had episode(s) of syncope (loss of consciousness or fainting) in the past two years?**

**Diagnosis:**

<<DESCRIPTION BOX>

Date of last occurrence:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(Check box) **Migraine or other severe headaches**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Any other symptom, condition, or surgery of the brain or nervous system (e.g., Guillain-Barre, peripheral neuropathy) for which you have sought medical attention in the past two years.**

(Checkbox) I was given a diagnosis for my symptoms.

Date:

<<DATE FIELD>>

Diagnosis:

<<DESCRIPTION BOX>>

(Check box) I don't know the name of condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**OPHTHALMOLOGY**

**(Conditions of the Eye)**

## In my lifetime I have/had:

(CHECK BOX) **Macular degeneration**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **Blindness**

**Please select the status that applies to you:**

**(CHECK BOX) I have partial blindness**

**(CHECK BOX) I have complete blindness**

Location:

- Left
- Right
- Both

When and how did your vision loss occur?

<<DESCRIPTION FIELD>>

(CHECK BOX) I was given a diagnosis for the cause of my irreversible blindness.

Describe:

<<DESCRIPTION FIELD>>

(CHECK BOX)The reason for my blindness is not known and I do not have a diagnosis.

(CHECK BOX) I currently use support modalities and/or assistive technology to manage daily activities and work.

Describe:

<<DESCRIPTION FIELD>>

(CHECK BOX) **Diabetic retinopathy**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **Ocular lesions (lesions that require scheduled exams, except melanoma)**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **Treatment with injectable drugs into eye (including any immunomodulators) for an eye condition**

Reason for treatment:

<<DESCRIPTION FIELD>>

(CHECK BOX) **Retinal detachment**

Date of diagnosis:

<<DATE FIELD>>

Location:

- Left
- Right
- Both

(CHECK BOX) **Uveitis**

Date of diagnosis:

<<DATA FIELD>>

(CHECK BOX) **Optic nerve disease (e.g., optic neuritis)**

Date of diagnosis:

<<DATA FIELD>>

(CHECK BOX) **Ophthalmologic (eye) surgery**

Reason for surgery:

<<DESCRIPTION FIELD>>

Date of surgery:

<<DATA FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE SELECTIONS BELOW:**

(CHECK BOX) I require prescription eye correction (either glasses or contacts).

<<Dropdown>>:

*Note: The Peace Corps Office of Medical Services strongly discourages Volunteers from wearing contact lenses while serving abroad,* ***unless there is a medical reason documented by an ophthalmologist.***

(CHECK BOX) I do not require prescription eye correction.

**YOU MUST CHECK ONE OF THE SELECTIONS BELOW:**

(CHECK BOX) In the **past two years**, I have seen a primary care physician or ophthalmology (eye) specialist for a condition or surgical procedure for the eyes or a medication refill (see below for a list of conditions).

(CHECK BOX) I have not seen a doctor in the **past two years** for any eye condition.

**Check all conditions or symptoms that apply**

(CHECK BOX) **I have had vision correction surgery such as Lasik.**

Date of surgery:

<<DATE FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **I am considering having Lasik/photorefractive keratectomy corrective surgery.**

*Note: A four-month post-operative period is required for medical clearance. Please plan accordingly.*

(CHECK BOX) **I have had temporary blindness.**

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATA FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Herpes infection of the eye that requires prescription medication (i.e., ocular herpes, shingles, keratitis)**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) **Lattice degeneration**

Date of diagnosis:

<<DATE FIELD>>

Location:

- Left
- Right
- Both

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Retinitis pigmentosa**

Date of diagnosis:

<<DATE FIELD>>

Location:

- Left
- Right
- Both

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Cataract(s)**

Date of diagnosis:

<<DATE FIELD>>

Location:

- Left
- Right
- Both

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I do not need surgery at this time.

(CHECK BOX) I had surgery due to this condition.

Date of surgery:

<<DATE FIELD>>

(CHECK BOX) I have been told I need, or may need, surgery in the future due to this condition.

Describe:

<<DESCRIPTION FIELD>>

(CHECK BOX) I have some limitation with my eyesight due to this condition (such as night blindness).

Describe:

<<DESCIRPTION FIELD>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Eyelid condition such as chalazion, hordeolum, conjunctivitis, or blepharitis**

Date of diagnosis:

<<DATE FIELD>>

Location:

- Left
- Right
- Both

Date of last occurrence:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I have some limitation with my eyesight due to this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I had surgery due to this condition.

(CHECK BOX) I have been told I need, or may need, surgery in the future due to this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Glaucoma**

Date of diagnosis:

<<DATA FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX)I have some limitation with my eyesight due to this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Any other eye symptom, diagnosed condition, or eye surgery not previously listed for which you have sought medical attention in the past two years**

(CHECK BOX) I was given a diagnosis for my symptoms.

List diagnosis:

<<DESCRIPTION FIELD>>

Date:

<<Date Field>>

(CHECK BOX)I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<Date Field>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) The cause of this condition is known and can be prevented.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX)I have some limitation with my eyesight due to this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I had surgery due to this condition in the past two years.

(CHECK BOX) I have been told I need, or may need, surgery in the future due to this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**Respiratory**

**(Conditions of Breathing and the Lungs)**

**CHECK ANY TRUE STATEMENT BELOW**

***In my lifetime*** **I have had (please choose all that apply):**

**(Check box) Lung cancer**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Surgery on my lungs**

Date of surgery:

<<DATE FIELD>>

Diagnosis:

<<DESCRIPTION FIELD>>

Type of Surgery: <<DROPDOWN: Lobectomy, Pulmonary, Biopsy, Bronchoscopy, Pleurodesis, Transplant, or other <<text box>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Chronic obstructive pulmonary disease (COPD) (emphysema and/or chronic bronchitis)**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Pulmonary embolism**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Fibrotic lung disease** (lung scarring, including sarcoidosis, lupus, idiopathic pulmonary fibrosis, other) << text box>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Cystic fibrosis**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

**(Check box) Pulmonary hypertension**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Asthma, reactive airway disease (RAD), or wheezing**

(Check box) I require inhaled medication **daily** to control asthma symptoms.

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(Check box) In the **past two years**, I have seen a primary care physician, allergist, or pulmonologist for a lung or breathing condition or a medication refill (see below for a list of conditions).
(Check box)I have not seen a doctor in the **past two years** for any lung condition.

(Check box) **Asthma, reactive airway disease (RAD), or wheezing**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(Check box) I require oral medication to control my asthma symptoms.

(Check box) I require inhaled medication to control my asthma symptoms.

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Pneumothorax (partial or total lung collapse)**

Date of diagnosis:

<<DATE FIELD>>

(Check box) I have had this condition more than once **in my lifetime**.

List dates:

<<DESCRIPTION BOX>>

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Sleep apnea history (current or resolved)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(Check box) I require the use of a C-PAP machine to manage.

If yes:

(Check box) I require reliable nighttime electricity for my C-PAP machine.

(Check box) I have a battery back-up and will require reliable electricity during the day to recharge.

(Check box) **Any other respiratory symptom, condition, or surgery not previously listed for which you have sought medical attention in the past two years.**

(Check box) I was given a diagnosis for my symptoms.

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I do not know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(Check box) I require oral medication to control my symptoms.

(Check box) I require inhaled medication to control my symptoms.

(Check box) I had surgery due to this condition **in the past two years**.

Describe:

<<DESCRIPTION BOX>>

(Check box) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**Rheumatology and Immunology**

**(Diseases caused by an overactive immune system and chronic inflammation)**

***Have you ever been diagnosed with any of the following conditions?***

**(Check box) Select all that apply:**

Ankylosing Spondylitis, Systemic Lupus Erythematosus, Polymyositis, Dermatomyositis, Scleroderma, Psoriatic Arthritis, Fibromyalgia, Chronic Fatigue Syndrome, Rheumatoid Arthritis, Juvenile Rheumatoid Arthritis Vasculitis, other with <<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(Check box) I am currently being treated for this condition.

<<DESCRIPTION BOX>>

**(Check box) I have been diagnosed with a rheumatological condition that required the use of immunosuppressants (including chronic steroids) or injectable drugs.**

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(Check box) In the **past two years**, I have seen a primary care physician, immunologist, or rheumatologist for any condition cause by chronic inflammation from an overactive immune system or ailments of the joints such as arthritis or a medication refill (see below for a list of conditions).

(Check box) I have not seen a doctor in the **past two years** for any condition caused by chronic inflammation from an overactive immune system, or ailment of the joints such as arthritis.

(Check box) **Reactive arthritis (Reiter's syndrome)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for specialized monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Sjogren's syndrome**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for specialized monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(Check box) **Any rheumatoid or immunologic symptom, diagnosed condition, or surgery not previously listed for which you have sought medical attention in the past two years.**

Diagnosis:

(Check box) I was given a diagnosis for my symptoms.

Date:

<<DATE FIELD>>

List diagnosis:

<<DESCRIPTION BOX>>

(Check box) I don't know the name of the condition causing my symptoms or I have not been given a diagnosis.

Date of initial symptoms:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>

(Check box) I have prescription medication for this condition.

(Check box) I require a specialist for specialized monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**UROLOGY AND NEPHROLOGY**

**(Conditions of the Urinary Tract, Bladder, or Kidney)**

**In my lifetime, I have had (please choose all that apply):**

(CHECK BOX) **Cancer or carcinoma of the urinary tract, bladder, or kidney**

Location: <<DROPDOWN: Testicle, Bladder, Kidney, other << textbox>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Kidney transplant**

Date of surgery:

<<DATE FIELD>>

Reason for transplant:

<<DESCRIPTION BOX>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Nephrectomy (not for kidney cancer or disease)**

Reason for surgery:

Describe:

<<DESCRIPTION BOX>>

Date of surgery:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Kidney and/or urethral stones**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I have had this condition more than once in my lifetime.

Date of most recent episode: <<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

<<CHECKBOX>> I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I follow a special diet due to having this condition.

Describe:

<<DESCRIPTION FIELD>>

**(CHECK BOX) Any other urologic or nephrology surgery (kidneys, ureters, bladder, urethra, or testes)**

Type of surgery:

Describe:

<<DESCRIPTION FIELD>>

Diagnosis:

<<DESCRIPTION BOX>>

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Solitary or horseshoe kidney**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I have had surgery for this condition.

Reason for surgery:

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Polycystic kidney disease**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) **Glomerulonephritis/nephritis (inflammation of the kidney)**

Date of diagnosis:

<<DATE FIELD>>

Cause of glomerulonephritis/nephritis:

Describe:

<<DESCRIPTION BOX>>

Status of condition is:

(CHECK BOX) Acute one-time occurrence

**OR**

(CHECK BOX) Chronic ongoing condition

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Renal failure**

Date of diagnosis:

<<DATE FIELD>>

Cause of the renal failure:

Describe:

<<DESCRIPTION BOX>>

Status of condition is:

(CHECK BOX) Acute one-time occurrence

**OR**

(CHECK BOX) Chronic ongoing condition

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Chronic bladder or pelvic pain (interstitial cystitis)**

Date of diagnosis:

<<DATE FIELD>>

(CHECK BOX) I am currently being treated for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**YOU MUST CHECK ONE OF THE STATEMENTS BELOW**

(CHECK BOX) In the **past two years,** I have seen a primary care physician, nephrologist, urologist, or other doctor for a urinary tract, bladder, or kidney condition or a medication refill (see list of conditions below).

(CHECK BOX) I have not seen a doctor in the **past two years** for any urinary tract, bladder, or kidney condition.

**Please check all conditions that apply.**

(CHECK BOX) **Recurrent cystitis, recurrent pyelonephritis, or other infections of the urinary tract (recurrent includes two episodes in a six-month period or more than two episodes in the last two years)**

Diagnosis: <<DROPDOWN: Cystitis, pyelonephritis, other << textbox >>

Date of initial diagnosis:

<<DATE FIELD>>

List number of episodes:

<<DESCRIPTION BOX>>

Date of most recent episode:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) Diagnosis**: Bladder cystocele (weakened, stretched bladder)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require personal care items (i.e., disposable or durable medical equipment) for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) Diagnosis: **Stress incontinence (loss of urinary control)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require personal care items (i.e., disposable or durable medical equipment) for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) Diagnosis: **Benign prostatic hypertrophy (enlargement of the prostate gland)**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require personal care items (i.e., disposable or durable medical equipment) for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) Diagnosis: **Any other abnormalities of the genitourinary tract**

<<DROPDOWN SELECT>> Male

Actual diagnosis: <<DROPDOWN: Undescended testicle, hydrocele, spermatocele, varicocele, urethral structure, neurogenic bladder, other <<text box>>

<<DROPDOWN SELECT>> Female

Actual diagnosis: <<DROPDOWN: Abnormality of the urinary tract, urethral structure, neurogenic bladder, other <<textbox>>

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) I have had this condition more than once in the last two years.

List number of times:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Diagnosis: Genital Herpes**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Diagnosis: Genital Ulcers**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

**(CHECK BOX) Diagnosis: Genital Warts**

Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION FIELD>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECK BOX) Diagnosis: **Any other kidney, bladder, urinary tract symptoms, or condition of the genitourinary system not previously listed for which you have sought medical attention in the past two years.**

Diagnosis: <<DROPDOWN: Cystitis, epididymitis, prostatitis, urethritis, other <<textbox >>

(CHECK BOX) Date of diagnosis:

<<DATE FIELD>>

How are you currently managing this condition?

<<DESCRIPTION BOX>>

(CHECK BOX) I have had this condition more than once in the last two years.

List dates:

<<DESCRIPTION BOX>>

(CHECK BOX) I have prescription medication for this condition.

(CHECK BOX) I currently require ongoing medical treatment for this condition.

Describe:

<<DESCRIPTION BOX>>

(CHECKBOX) I require a specialist for monitoring and/or follow-up for this condition.

Describe:

<<DESCRIPTION BOX>>

## CLOSING QUESTIONS

**The questions in the section below refer to any conditions *that you have not already provided information*.**

<<Yes/No>> I have chronic or active condition(s) that are not previously listed or described.

If Yes, Describe:

<<DESCRIPTION BOX>>

<<Yes/No>> I have chronic pain that has not been previously listed or described.

If Yes, Describe:

<<DESCRIPTION BOX>>

<<Yes/No>> I use medical equipment (either daily or as needed) that has not been previously listed

If Yes,

Select all that apply:

(CHECK BOX) Insulin pump

(CHECK BOX) C-PAP machine

(CHECK BOX) Compressive device

(CHECK BOX) Wheelchair, cane, walker, crutches

(CHECK BOX) Hearing aid

(CHECK BOX) Pacemaker or defibrillator

(CHECK BOX) Prosthetic device

(CHECK BOX) Other medical equipment that requires the use of batteries or electricity for maintenance

Describe: <<Description Box>>

<<Yes/No>> Based on a condition (or conditions) I've listed in this questionnaire, I believe that I will need special medical support.

If Yes, Please describe the support you may need:

<<DESCRIPTION BOX>>