RADIANT Questionnaire Section 4

You are more than halfway done! You have completed 3 sections so far and have only 2 sections to go.

This section asks questions about your birth and medical history. This information could provide clues about unusual forms of diabetes. Please answer the questions below and then continue to the next section.

Note: If you are completing this questionnaire on behalf of the study participant, "you" means "the study participant".

Birth History

Please estimate your birth size:
o Normal size
o Bigger than normal
o Smaller than normal
o Don't Know
o Prefer Not to Answer

Did you have any of the following features when you were born? Check all that apply.
☐ Low blood sugar (hypoglycemia) after birth
☐ High blood sugar (hyperglycemia) after birth
☐ Coarse skin
☐ Umbilical hernia
☐ Inguinal hernia
☐ Large tongue (macroglossia)
☐ Large liver
☐ Muscular body
☐ Other, **Please specify feature: _____**
☐ None of the above
☐ Don't Know
☐ Prefer Not to Answer

Did your mom have any health problems during her pregnancy or delivery with you, or have you had any problems related to your birth?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What type of problem(s)? Check all that apply.
☐ My mom had health problems during her pregnancy with me
☐ Problems at birth
☐ Problems as a baby
☐ None of the above
☐ Don't Know

☐ Prefer Not to Answer

Medical History

Please consider all current and previous medical problems/conditions when answering the questions below.

Lipodystrophy

Do you have a diagnosis of lipodystrophy or does your doctor suspect that you have it?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes, complete the lipodystrophy questions below. Otherwise, skip to the monogenic diabetes (MODY or neonatal diabetes) section on the next page.

Have you had genetic testing done for lipodystrophy?

o Yes o No o Don't Know

If Yes:

Did the genetic testing reveal a cause for your lipodystrophy?

o Yes – the result showed a definitive cause of my lipodystrophy
o No – the results were completely negative
o Maybe – there were genetic variant(s) or mutation(s) that "might" explain the lipodystrophy but my doctor and/or the testing lab were unsure (usually called "variant of uncertain significance")
o Don't Know
o Prefer Not to Answer

Do you have a copy of your genetic testing results?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: Please attach a copy of your genetic testing report to this questionnaire.

If No:

Why has genetic testing not yet been done?

o My insurance won't cover it or it is too expensive
o My provider was unsure about whether I should have genetic testing
o My provider was unsure about which genes to test
o My provider was unsure where/how to have the genetic testing done
o Other
o Don't Know
o Prefer Not to Answer

If Other, please specify why genetic testing has not been done:
_____

Monogenic Diabetes (MODY or neonatal diabetes)

Do you have a diagnosis of monogenic diabetes (MODY or neonatal diabetes) or does your doctor suspect that you have it?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes, complete the monogenic diabetes questions below. Otherwise, skip to the mitochondrial/syndromic diabetes section on the next page.

Have you had genetic testing done for monogenic diabetes?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes:

Did the genetic testing reveal a cause for your diabetes?

o Yes – the result showed a definitive cause of my diabetes
o No – the results were completely negative
o Maybe – there were genetic variant(s) or mutation(s) that "might" explain the diabetes but my doctor and/or the testing lab were unsure (usually called "variant of uncertain significance")
o Don't Know
o Prefer Not to Answer

Do you have a copy of your genetic testing results?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: Please attach a copy of your genetic testing report to this questionnaire.

If No:

Why has genetic testing not yet been done?

o My insurance won't cover it or it is too expensive
o My provider was unsure about whether I should have genetic testing
o My provider was unsure about which genes to test
o My provider was unsure where/how to have the genetic testing done
o Other
o Don't Know
o Prefer Not to Answer

If Other, please specify why genetic testing has not been done: _____

Mitochondrial/Syndromic Diabetes

Do you have a diagnosis of mitochondrial or similar form of diabetes (sometimes called syndromic diabetes, e.g., Wolfram syndrome, MELAS, MIDD) or does your doctor suspect that you have it?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes, complete the mitochondrial/syndromic diabetes questions below. Otherwise, skip to the growth/puberty section on the next page.

Have you had genetic testing done for mitochondrial or syndromic diabetes?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes:

Did the genetic testing reveal a cause for your diabetes?

o Yes – the result showed a definitive cause of my diabetes
o No – the results were completely negative
o Maybe – there were genetic variant(s) or mutation(s) that "might" explain the diabetes but my doctor and/or the testing lab were unsure (usually called "variant of uncertain significance")
o Don't Know
o Prefer Not to Answer

Do you have a copy of your genetic testing results?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: Please attach a copy of your genetic testing report to this questionnaire.

If No:

Why has genetic testing not yet been done?

o My insurance won't cover it or it is too expensive
o My provider was unsure about whether I should have genetic testing
o My provider was unsure about which genes to test
o My provider was unsure where/how to have the genetic testing done
o Other
o Don't Know
o Prefer Not to Answer

If Other, please specify why genetic testing has not been done: _____

Have you had any problems related to your growth or puberty?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What problem(s)? Check all that apply.

☐ Growth pattern problems

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Puberty problems

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Other growth or puberty problem

Please specify other growth or puberty problem: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know
☐ Prefer Not to Answer

Have you had any Brain or Nervous System Conditions?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Abnormal MRI or CT

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Abnormal pain threshold

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Cerebral palsy

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Chronic fatigue

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Concussion or loss of consciousness

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Dementia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Disabilities

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Epilepsy or seizure or abnormal EEG

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Insomnia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Lou Gehrig's Disease (Amyotrophic Lateral Sclerosis or ALS)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Memory loss or impairment

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Migraine headaches

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Multiple sclerosis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Muscular Dystrophy (MD)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Narcolepsy

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Neuropathy (including diabetic neuropathy)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Parkinson's disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Restless leg syndrome

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Spinal cord injury or impairment

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Traumatic brain injury (TBI)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other brain or nervous system condition

Please specify other brain or nervous system condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Mental Health Conditions, Behavioral Conditions, Developmetnal Conditions, or problems with Neurological Development?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What problem(s)? Check all that apply.

☐ Anxiety reaction/panic disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Attention Deficit Hyperactivity Disorder (ADHD)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Autism Spectrum Disorder or problems with social behaviors

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Bipolar disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Depression

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Eating disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Learning delay or learning impairment

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Personality disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Post-traumatic stress disorder (PTSD)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Problems with developmental milestones

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Problems with motor skills and functions

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Problems with cognitive status

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Schizophrenia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Social phobia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other mental health, behavioral, developmental, or neurological development condition

Please specify other mental health, behavioral, developmental, or neurological development condition: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current problem?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Substance Use Conditions?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Alcohol use disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Drug use disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Other substance use condition

Please specify other substance use condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Eye, Vision, Hearing, Speech, Head, or Neck Conditions?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Astigmatism

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Blindness, all causes

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Cataracts

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Colorblindness

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Diabetic retinopathy

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Dry eyes

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Farsighted

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Glaucoma

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Macular degeneration

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Nearsighted

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Severe hearing loss or partial deafness in one or both ears

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Speech problems

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Tinnitus

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Uncorrectable vision loss

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Unusual appearance

Please explain unusual appearance: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other eye, vision, hearing, speech, head or neck condition

Please specify other eye, vision, hearing, speech, head or neck condition:_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Skin, Muscle, or Fat Conditions?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Muscle weakness in shoulders or hips

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Muscle weakness in hands or feet

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Muscle weakness in face

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Skin darkening on body creases such as the back of the neck or the armpits (also called "acanthosis nigricans")

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Too little fat

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Too much fat

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Unusual body shape

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Unusual fat distribution and/or very muscular extremities

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other Skin conditions

Please specify other skin condition: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Bone or Joint Conditions? (This includes broken bones.)

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Abnormal shape bones or skeleton

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Carpal tunnel syndrome

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Fibromyalgia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Fractured/broken any bones

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Gout or unusually high uric acid

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Osteoarthritis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Osteoporosis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Pseudogout

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Rheumatoid arthritis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Spine, muscle, or bone disorders (non-cancer)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Systemic lupus

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other arthritis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other bone, joint or muscle condition

Please specify other bone, joint or muscle condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

If you checked abnormal shape bones or skeleton, which parts of your body are an abnormal shape? Check all that apply.

☐ Head (big/small)

☐ Limbs (short/long/mismatched)

☐ Fingers/toes (too many, too few, curved)

☐ Spine (curved, spina bifida)

☐ Other

Please explain which other parts of your body are abnormally shaped:_____

Have you had any Heart or Blood Vessel Conditions?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Atrial fibrillation (Afib) or Atrial flutter

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Cardiomyopathy

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Congestive heart failure

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Coronary artery/coronary heart disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Electrical conduction problems

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Heart attack

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Heart valve disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hypertension (high blood pressure)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Orthostatic Hypotension (low blood pressure on standing)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Peripheral vascular disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Pulmonary embolism or deep vein thrombosis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Stroke

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Transient ischemic attacks (TIAs or mini-strokes)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other heart or blood vessel condition

Please specify other heart or blood vessel condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Lung Conditions?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Asthma

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Chronic Lung Disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Sleep Apnea

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other lung condition

Please specify other lung condition:_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Digestive or Bowel Conditions?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Acid reflux
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Bowel obstruction
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Celiac disease
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Cirrhosis
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Colon polyps
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Crohn's disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Diverticulosis/diverticulitis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Fatty liver disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Gall stones

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Gastroparesis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hemorrhoids

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hepatitis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hernia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Irritable bowel syndrome (IBS)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other liver condition

Please specify other liver condition: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Pancreatitis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Peptic ulcers

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Ulcerative colitis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other digestive or bowel condition

Please specify other digestive or bowel condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Kidney or Urogenital Conditions, or any Reproductive or Fertility Problems?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Abnormal genitalia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Abnormal ureter/drainage system

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Abnormal uterus

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Ectopic pregnancies

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ History of miscarriage(s)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Infertility

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Irregular menses (periods)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Kidney cysts

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Kidney stones

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Kidney disease not requiring dialysis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Kidney disease with dialysis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other Kidney or Urogenital Condition

Please specify other kidney or urogenital condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Unusual kidney shape or number

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Urethra abnormality

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other Reproductive or Fertility Problem

Please specify other reproductive or fertility problem:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know
☐ Prefer Not to Answer

Have you had any Hormone Conditions?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Abnormal appetite or thirst
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Adrenal
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Autoimmune gland disease
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Bothersome, increased hair growth on my body (face, arms/legs, abdomen, back, buttocks)
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Decreased levels of male hormone levels and/or required testosterone therapy
Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years
Ongoing or current condition?
o Yes o No o Don't Know o Prefer Not to Answer
Currently receiving treatment?
o Yes o No o Don't Know o Prefer Not to Answer

☐ Diabetes Insipidus (water diabetes)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Excessive hair loss from my scalp

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Excessive sweating or flushing

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Increased levels of male hormone levels

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Parathyroid/calcium

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Pituitary function

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Polycystic ovarian syndrome (PCOS)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Pubertal acceleration or delay

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Sex steroid production

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Temperature regulation abnormalities (ex. heat or cold sensitivity)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Thyroid

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Weight regulation abnormalities

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other hormone condition

Please specify other hormone condition: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

If bothersome, increased hair growth: Which area(s) have bothersome, increased hair growth? Check all that apply.

☐ Face

☐ Arms/legs

☐ Abdomen

☐ Back

☐ Buttocks

Have you had any Metabolic Conditions?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Abnormal levels of fat in the blood (high 'bad' cholesterol, low 'good' cholesterol, high triglycerides)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Insulin resistance

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Unusually high urea levels

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other metabolic condition

Please specify other metabolic condition: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Immune System Conditions?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Autoimmune disease (known or suspected)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Frequent serious infections

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Failure to heal

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Immune dysfunction syndrome

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other immune system condition

Please specify other immune system condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Blood/Hematology Conditions?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What condition(s)? Check all that apply.

☐ Anemia

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Bleeding disorder

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Clotting problems

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Sickle cell disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Swollen lymph nodes

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Unusual cells in the blood

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other blood/hematology condition

Please specify other blood/hematology condition:

_____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had Cancer?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What type(s) of cancer? Check all that apply.

☐ Bladder cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Blood or soft tissue cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Bone cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Brain cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Breast cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Cervical cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Colon cancer/Rectal cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Endocrine cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Endometrial cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Esophageal cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Eye cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Head and Neck cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Kidney cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Liver cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Lung cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Ovarian cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Pancreatic cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Prostate cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Skin cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Stomach cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Thyroid cancer

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other cancer

Please specify other type of cancer: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you had any Infections? (This includes COVID, chickenpox, sinus infection, urinary tract/bladder infections, and infectious diseases.)

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What infection(s)? Check all that apply.

☐ Chickenpox

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Chronic sinus infections

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ COVID-19

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

If you have had COVID-19:

Please list all the times you have ever had COVID-19:

	Date COVID-19 illness began (approximate date is okay)	**Did you have symptoms?**	**Were you hospitalized for this illness?**	**Provide additional information, such as medications, on COVID-19 illness, if desired:**
COVID-19 illness #1		○ Yes ○ No	○ Yes ○ No	
COVID-19 illness #2		○ Yes ○ No	○ Yes ○ No	
COVID-19 illness #3		○ Yes ○ No	○ Yes ○ No	
COVID-19 illness #4		○ Yes ○ No	○ Yes ○ No	

If you have had COVID-19 more than 4 times, please continue this table on a separate sheet of paper and attach it to this questionnaire.

Have you experienced any of the following "long COVID" symptoms? (Check all that apply)

Long COVID is defined as symptoms lasting three or more months after first contracting the virus, and that you did not have prior to your COVID-19 infection.

□ I have not experienced any "long COVID" symptoms
□ Tiredness or fatigue
□ Difficulty thinking, concentrating, forgetfulness, or memory problems (sometimes referred to as "brain fog")
□ Difficulty breathing or shortness of breath
□ Joint or muscle pain
□ Fast-beating or pounding heart (also known as heart palpitations)
□ Chest pain
□ Dizziness on standing
□ Menstrual changes
□ Changes to taste/smell
□ Inability to exercise or change in exercise tolerance

Have you received a COVID-19 vaccination?
o Yes o No o Prefer Not to Answer

☐ Dengue fever

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hepatitis A

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hepatitis B

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Hepatitis C

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ HIV/AIDS

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Lyme disease

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Recurrent urinary tract infections (UTI)/bladder infections

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Reoccurring yeast infection

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Severe acute respiratory syndrome (SARS)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Sexually transmitted infections (Gonorrhea, Syphilis, Chlamydia)

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Shingles

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Tuberculosis

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ West Nile virus

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Zika virus

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Other infectious disease

Please specify other infectious disease: _____

Age when diagnosed? (Leave blank if you Don't Know or Prefer Not to Answer) ___ Years

Ongoing or current condition?

o Yes o No o Don't Know o Prefer Not to Answer

Currently receiving treatment?

o Yes o No o Don't Know o Prefer Not to Answer

☐ Don't Know

☐ Prefer Not to Answer

Have you been exposed to higher than usual levels of one or more of the following: Agent Orange, dioxin, bisphenol-A, or other pesticides?

o Yes o No o Don't Know o Prefer Not to Answer

If yes, please explain what you were exposed to, how you were exposed, and when you were exposed:

_____

_____

_____

Have you had any Allergies?

o Yes o No o Don't Know o Prefer Not to Answer

If Yes: What type(s)? Check all that apply.

☐ Allergies to medications

☐ Other allergies

☐ Don't Know

☐ Prefer Not to Answer

If Other, please specify other allergies: _____

Have you had any Surgical procedures? (ex: cholecystectomy, hysterectomy, etc.)
o Yes o No o Don't Know o Prefer Not to Answer

Surgical Procedure	Approximate Date of Procedure (MM-DD-YYYY)	Your age when you had the procedure (in years)

If you have additional surgical procedures to list, please write the surgical procedure information (procedure name, approximate date of procedure, and your age in years when you had the procedure) on a separate sheet of paper and attach it to this questionnaire.

Have you had any other medical problems?
o Yes o No o Don't Know o Prefer Not to Answer

If Yes: please explain any other medical problems:
_____
_____

Thank you for completing this section! Please continue to the next section.