Name: ____

Tell us about you! We are glad you are a part of ongoing research efforts!

Medical Problem	Date Problem Began	Medicine For Problem	Date Medicine Began	Amount of Medicine For Problem
AIDS/HIV				
Anxiety				
Allergies/Asthma				
Blood Clots				
Cancer Type:________				
Depression				
Diabetes Type:______				
Heart Problems				
Hepatitis (B,C)				
High Blood Pressure				
High Cholesterol				
Joint Problems				
Kidney Problems				
Stomach Problems				
Thyroid (High, Low)				
Tuberculosis				
Seasonal Allergies				
Other:_____________				
___________________				

Surgeries and Birth Control	Date (month, day, and year)	What did you have done?
Menopause		
Hysterectomy		
Removal of Ovaries		
Tubal Ligation		
IUD		
Birth Control:______ ___________________		
Vasectomy		
Other:_____________		
___________________		