

If yes, please tell what they are: \_\_\_\_\_

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3. Since your last evaluation, have you been in the hospital for any illnesses, injuries, or surgery?

yes    no

If yes, please describe: \_\_\_\_\_

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4. Do you have any of the following? Please place a check for all that apply to you.

- |                      |       |                         |       |
|----------------------|-------|-------------------------|-------|
| unexplained fever    | _____ | liver disease           | _____ |
| anemia ("low blood") | _____ | cancer                  | _____ |
| HIV/AIDS             | _____ | infertility             | _____ |
| weakness             | _____ | drinking problems       | _____ |
| sickle cell          | _____ | thyroid problems        | _____ |
| miscarriage          | _____ | night sweats            | _____ |
| skin rash            | _____ | still birth             | _____ |
| bloody rash          | _____ | eye redness             | _____ |
| leukemia/lymphoma    | _____ | lumps you can feel      | _____ |
| neck mass/swelling   | _____ | child with birth defect | _____ |
| wheezing             | _____ | autoimmune disease      | _____ |
| chest pain           | _____ | overly tired            | _____ |
| bruising easily      | _____ | lung problems           | _____ |
| lupus                | _____ | rheumatoid arthritis    | _____ |
| weight loss          | _____ | mononucleosis "mono"    | _____ |
| kidney problems      | _____ | nagging cough           | _____ |
| enlarged lymph nodes | _____ | yellowing of skin       | _____ |