



Personal Medical History

The questions in this section will help us understand your personal medical history. This section will take 10 min to complete.

Q1: Have you ever been diagnosed with one or more of the following by a professional?

By professional we mean: doctor, nurse or other person with specialist health training (e.g. psychologist). Please include disorders even if you do not need or want treatment for them and even if you personally disagree with the diagnosis

	-No; -Yes; -Maybe/not sure: -Not applicable			Which year did this problem first appear?	Is the problem ongoing	Did you receive treatment for this problem?	Is the treatment ongoing?
	Yes	No	Not sure				
High blood pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
High Cholesterol	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Stroke	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Heart Attack	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Heart Failure	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Abnormal heart rhythm	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Any other heart condition	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Bleeding problems	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Blood clotting problems	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Sickle cell anaemia	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Diabetes (high blood sugar) – Type 1	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Diabetes (high blood sugar)- Type 2	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Breast Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Prostate Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Cancer of the ovaries or testicles	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Liver Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Lung Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Colon Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Any blood cancer (e.g. leukemia)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				



Any other cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Chronic kidney disease (transplant or dialysis)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Inflammatory bowel disease (e.g. Crohn's)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Irritable bowel disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Severe joint disease (e.g. rheumatoid arthritis)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Osteoporosis	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Chronic lung problems (e.g. emphysema)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Asthma	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Sarcoidosis	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Lupus	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Other autoimmune disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Seizures	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Alzheimer's Disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Parkinson's Disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Huntington's Disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Any other dementia	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Multiple Sclerosis	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Amyotrophic lateral sclerosis (Lou Gehrig's disease)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Migraines	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Depression	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Bipolar disorder (manic depressive disorder; mania or hypomania)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Schizophrenia or any psychotic disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Anxiety disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Social anxiety	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Specific phobias (e.g. closed spaces, heights)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Agoraphobia (fear of going out or being in public spaces)	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Panic attacks	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				



Post-traumatic stress disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Obsessive compulsive Disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Eating disorder-Anorexia	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Eating disorder-Bulimia	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Autism, Asperger's or autism spectrum disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Attention Deficit Hyperactivity Disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Any other mental disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Drug addiction	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				
Alcohol addiction	Y <input type="checkbox"/>	N <input type="checkbox"/>	NS <input type="checkbox"/>				