MEDICAL HISTORY QUESTIONNAIRE

These are the questionnaire sections you will complete:

1. Additional Report opt-in or opt-out
2. Personal information
3. Shipping address
4. COVID-19 infection and vaccination
5. General medical background
6. Infectious diseases history
7. Autoimmune diseases history
8. Cancer history
9. Fatigue syndromes

Please answer the questionnaire to the best of your ability.
Questions marked with an asterisk are required.

Click the button to save your information and move to the next page.

START

1. ADDITIONAL REPORT

Aside from the report on your antibodies against COVID-19, you also have the opportunity to receive a report of your antibodies against other infectious diseases (Lyme, Anaplasmosis, Babesiosis, Ehrlichiosis, Chagas Disease) and to Deamidated Gliadin (a marker of Celiac Disease).

If you would like to receive this additional report, click the checkbox below:

☐ **I would like to receive the additional antibody report**

2. PERSONAL INFORMATION

Questions marked with an asterisk are required.

Age (years) *

Country of Origin *

Select a country

Sex

○ Male ○ Female ○ Choose not to disclose

3. SHIPPING ADDRESS

Please provide the address where you'd like to receive your blood collection kits.
Questions marked with an asterisk are required.

Address line 1 *

Address line 2

City *

State *

Select State

Zip Code *

Cell Phone Number *

4. COVID-19

Please answer the questions to the best of your ability.
Only questions marked with an asterisk are required.
Click Submit to save your information and move to the next page.

Have you been vaccinated against COVID-19? *

○ Yes ○ No

Have you ever been exposed to a confirmed COVID-19 case, but were not confirmed or tested yourself? *

○ Yes ○ No

Have you ever been diagnosed with COVID-19? *

○ Yes ○ No

Have you ever been diagnosed with Long Haul COVID? *

○ Yes ○ No

5. GENERAL MEDICAL BACKGROUND

Do you have a history of any of the following?

High Blood Pressure

○ Yes ○ No ○ Skip

Coronary Artery Disease

○ Yes ○ No ○ Skip

Chronic Kidney Disease

○ Yes ○ No ○ Skip

Chronic Obstructive Pulmonary Disease

○ Yes ○ No ○ Skip

Do you have a history of smoking?

○ Yes ○ No ○ Skip

6. INFECTIOUS DISEASES

Have you ever been diagnosed with any of the following infections?

Anaplasmosis
○ Yes ○ No ○ Skip
Date of diagnosis

Babesiosis
○ Yes ○ No ○ Skip
Date of diagnosis

Chagas disease
○ Yes ○ No ○ Skip
Date of diagnosis

Dengue virus
○ Yes ○ No ○ Skip
Date of diagnosis

Erlichiosis
○ Yes ○ No ○ Skip
Date of diagnosis

Hepatitis B
○ Yes ○ No ○ Skip
Date of diagnosis

Hepatitis C
○ Yes ○ No ○ Skip
Date of diagnosis

HIV
○ Yes ○ No ○ Skip
Date of diagnosis

HTLV
○ Yes ○ No ○ Skip
Date of diagnosis

Lyme disease
○ Yes ○ No ○ Skip
Date of diagnosis

Malaria
○ Yes ○ No ○ Skip
Date of diagnosis

West Nile virus
○ Yes ○ No ○ Skip
Date of diagnosis

Zika virus
Date of diagnosis

7. AUTOIMMUNE DISEASES

Have you ever been diagnosed with any of the following autoimmune conditions?

Celiac disease

○ Yes ○ No ○ Skip

Crohn's disease

○ Yes ○ No ○ Skip

Graves' disease

○ Yes ○ No ○ Skip

Hashimoto's thyroiditis

○ Yes ○ No ○ Skip

Multiple sclerosis

○ Yes ○ No ○ Skip

Myasthenia gravis

○ Yes ○ No ○ Skip

8. CANCER

Have you ever been diagnosed with cancer?

Have you ever been diagnosed with cancer?

○ Yes ○ No ○ Skip

Type of cancer

Approximate date of diagnosis?

Are you currently being treated for cancer with chemotherapy?

○ Yes ○ No ○ Skip

Are you currently taking any therapeutic antibodies for cancer?

○ Yes ○ No ○ Skip

9. FATIGUE

Have you ever been diagnosed with any of the following?

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)

○ Yes ○ No ○ Skip

Fibromyalgia

○ Yes ○ No ○ Skip

Long COVID fatigue

○ Yes ○ No ○ Skip

Post-Treatment Lyme Disease Syndrome (PTLDS)

○ Yes ○ No ○ Skip

Postural Orthostatic Tachycardia Syndrome (POTS)

○ Yes ○ No ○ Skip

Post-Exertional Malaise (PEM)

○ Yes ○ No ○ Skip

Are you currently experiencing fatigue symptoms?

○ Yes ○ No

Have you tested positive for Epstein-Barr virus reactivation?

○ Yes ○ No

Have you tested positive for autoantibodies?

○ Yes ○ No