

Have you ever been diagnosed with any of the following? Yes No

Within the last school year, have you had any of the following? Yes No

43. (Please make two marks in the appropriate columns for each row)

Allergy problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anorexia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bulimia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Fatigue Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endometriosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital herpes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital warts/HPV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B or C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Have you ever been diagnosed with any of the following? Yes No

Within the last school year, have you had any of the following? Yes No

Repetitive stress injury (e.g. carpal tunnel syndrome)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seasonal Affective Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance abuse problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Broken bone/fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chlamydia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ear infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gonorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pelvic Inflammatory Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strep throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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The next question asks about impediments to academic performance.

- Received an incomplete or dropped the course
- Received a lower grade in the course
- Received a lower grade on an exam or important project
- I have experienced this issue but my academics have not been affected
- This did not happen to me/not applicable

44. Within the last school year, have any of the following affected your academic performance? (Please select the most serious outcome for each item below)

Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assault (physical)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assault (sexual)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attention Deficit Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cold/Flu/Sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concern for a troubled friend or family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic illness (diabetes, asthma, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Death of a friend or family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression/Anxiety Disorder/Seasonal Affective Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating disorder/problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Internet use/computer games	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy (yours or your partner's)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus infection/ear infection/bronchitis/strep throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>