1. **Does the participant/subject have a history of the following medical problems/conditions?**

| **Medical History Term** | **Start Date** (mm/dd/yyyy) | **Ongoing?** | **End Date** (mm/dd/yyyy) |
| --- | --- | --- | --- |
| **Integumentary** |  |  |  |
| Skin ulcers |  | Yes  No |  |
| **Endocrine** |  |  |  |
| Growth delay |  | Yes  No |  |
| Osteopenia |  | Yes  No |  |
| Hypogonadism |  | Yes  No |  |
| Diabetes mellitus |  | Yes  No |  |
| Thyroid disorders |  | Yes  No |  |
| Adrenal disorders |  | Yes  No |  |
| **Rheumatologic/Immunologic** |  | Yes  No |  |
| Systemic Lupus Erythematosus |  | Yes  No |  |
| Rheumatoid Arthritis |  | Yes  No |  |
| Goodpasture’s syndrome |  | Yes  No |  |
| Autoimmune hemolytic anemia |  | Yes  No |  |
| Reiter’s syndrome |  | Yes  No |  |
| Systemic necrotizing vasculitis |  | Yes  No |  |
| Gout |  | Yes  No |  |