

## RADIANT Family History Questionnaire

This questionnaire asks questions about your family history, which may help us better understand your type of diabetes. Please answer the questions and click “Submit” at the bottom of the page when you are finished.

**If you need to take a break at any time, click “Save & Return Later” at the bottom of the page. Your responses so far will be saved and you can return to the Participant Portal later to login and finish.**

**Who is filling out this questionnaire for the RADIANT participant?**

- ☐ Self
- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Aunt or uncle
- ☐ Brother or sister
- ☐ Spouse or significant other
- ☐ Other

**If Other: What is the relationship of the person filling out this questionnaire to the participant?** Example: Legal Guardian. **\*\*Please do not write the person’s name.\*\***

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***IMPORTANT: In the questions below “YOU” and “YOUR” refers to the RADIANT participant. “Biological” means related to you by blood.***

### **Section 1 Family Race/Ethnic Background**

This section asks questions about your biological mother and father’s race and ethnicity. Biological means related to you by blood. This information may help us better understand the type of diabetes you have, as individuals of different races/ethnicities can have different levels of risk for certain types of diabetes.

**Please choose the option(s) below that best describes your biological father. Please select one or more if applicable.**

- ☐ American Indian or Alaska Native – a person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment
- ☐ Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- ☐ Black or African, African American, Afro-Caribbean – a person having origins in any of the black racial groups of Africa
- ☐ Native Hawaiian or other Pacific Islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- ☐ White – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa
- ☐ Don’t Know
- ☐ Prefer Not to Answer

**Is your biological father Hispanic, Latino, or of Spanish origin?**

- ☐ Yes
- ☐ No
- ☐ Don’t Know
- ☐ Prefer Not to Answer

**Please choose the option(s) below that best describes your biological mother. Please select one or more if applicable.**

- ☐ American Indian or Alaska Native – a person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment
- ☐ Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- ☐ Black or African, African American, Afro-Caribbean – a person having origins in any of the black racial groups of Africa
- ☐ Native Hawaiian or other Pacific Islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- ☐ White – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa
- ☐ Don't Know
- ☐ Prefer Not to Answer

**Is your biological mother Hispanic, Latino, or of Spanish origin?**

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Prefer Not to Answer

**Do you have any Ashkenazi Jewish ancestry?**

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Prefer Not to Answer

**Is there any chance that your biological parents are related by blood, for example first cousins?**

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Prefer Not to Answer

**If Yes, please describe how they are related:** \_\_\_\_\_

## Section 2 Family Member Health History

Please fill out the following information regarding your family health history. Please only include information about your *biological* family members (family members related to you by blood). This information may help us better understand your type of diabetes. We would like to know about all the biological family members we ask about below, including those with medical conditions, such as diabetes, and those without.

Because certain conditions and traits run in families, it may be helpful for some of your family members to participate in parts of this study in the future, regardless of whether they have diabetes. In the table below, we will ask you if you think your family members may be interested in participating in this study. We will let you know in the future if we find it would be helpful for your family members to participate in RADIANT. In that case, we would provide resources to assist you in communicating with your family members about the study and how to participate should they choose to.

Your Biological Parents & Grandparents										
	Current Age (if alive; in years)	Age at Death (in years)	Cause of Death	Medical Conditions (Please indicate whether your family member had any of the medical conditions listed below by selecting Yes, No, or Don't Know next to the condition.)				Age when diagnosed in years (Estimate age, or leave blank if you don't know)	Other Diagnosed Medical Conditions and Age at Diagnosis (in years)	Do you think this family member might be interested in participating in this study?
				Condition	Yes	No	Don't Know			
Your mother				Type 1 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Yes
				Type 2 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> No
				Diabetes - Other/Unknown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Don't Know
				Type:						
				Diabetes Treatment:						
				o Insulin shots						
				o Diabetes pills						
				o Both						
				o Neither						
				o Don't know						
				Hearing Loss before age 40:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Vision Loss:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Obesity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipodystrophy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Cardiomyopathy/enlarged	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				heart:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipid/fat/cholesterol disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Kidney Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Other autoimmune disorders:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Your father				Type 1 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Yes
				Type 2 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> No
				Diabetes - Other/Unknown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Don't Know
				Type:						
				Diabetes Treatment:						

				<input type="radio"/> Insulin shots <input type="radio"/> Diabetes pills <input type="radio"/> Both <input type="radio"/> Neither <input type="radio"/> Don't know Hearing Loss before age 40: Vision Loss: Obesity: Lipodystrophy: Cardiomyopathy/enlarged heart: Lipid/fat/cholesterol disorder: Kidney Problems: Other autoimmune disorders:	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>			
Your mother's mother (maternal grandmother)				Type 1 Diabetes: Type 2 Diabetes: Diabetes - Other/Unknown Type: Diabetes Treatment: <input type="radio"/> Insulin shots <input type="radio"/> Diabetes pills <input type="radio"/> Both <input type="radio"/> Neither <input type="radio"/> Don't know Hearing Loss before age 40: Vision Loss: Obesity: Lipodystrophy: Cardiomyopathy/enlarged heart: Lipid/fat/cholesterol disorder: Kidney Problems: Other autoimmune disorders:	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
Your mother's father (maternal grandfather)				Type 1 Diabetes: Type 2 Diabetes: Diabetes - Other/Unknown Type: Diabetes Treatment: <input type="radio"/> Insulin shots <input type="radio"/> Diabetes pills <input type="radio"/> Both <input type="radio"/> Neither <input type="radio"/> Don't know Hearing Loss before age 40: Vision Loss:	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

				Obesity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipodystrophy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Cardiomyopathy/enlarged heart:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipid/fat/cholesterol disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Kidney Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Other autoimmune disorders:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Your father's mother (paternal grandmother)				Type 1 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
				Type 2 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Diabetes - Other/Unknown Type:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Diabetes Treatment:						
				<input type="radio"/> Insulin shots						
				<input type="radio"/> Diabetes pills						
				<input type="radio"/> Both						
				<input type="radio"/> Neither						
				<input type="radio"/> Don't know						
				Hearing Loss before age 40:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Vision Loss:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Obesity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipodystrophy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Your father's father (paternal grandfather)				Cardiomyopathy/enlarged heart:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
				Lipid/fat/cholesterol disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Kidney Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Other autoimmune disorders:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Type 1 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Type 2 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Diabetes - Other/Unknown Type:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Diabetes Treatment:						
				<input type="radio"/> Insulin shots						
				<input type="radio"/> Diabetes pills						
				<input type="radio"/> Both						
				<input type="radio"/> Neither						
				<input type="radio"/> Don't know						
				Hearing Loss before age 40:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Vision Loss:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Obesity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipodystrophy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Cardiomyopathy/enlarged heart:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Lipid/fat/cholesterol disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Kidney Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
				Other autoimmune disorders:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			

Do you have any biological brothers or sisters?

☐ Yes

☐ No

☐ Don't Know

Your Biological Brothers and Sisters										
	Sex at Birth	Same biological I mom as you?	Same biological I dad as you?	Current Age (if alive; in years)	Age at Death (in years)	Cause of Death	Medical Conditions (Please indicate whether your family member had any of the medical conditions listed below by selecting Yes, No, or Don't Know next to the condition.)	Age when diagnosed in years (Estimate age, or leave blank if you don't know)	Other Diagnosed Medical Conditions and Age at Diagnosis (in years)	Do you think this family member might be interested in participating in this study?
							Condition	Yes	No	Don't Know
Brother/ Sister #1	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				Type 1 Diabetes: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Type 2 Diabetes: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Diabetes - Other/Unknown Type: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Diabetes Treatment: <input type="radio"/> Insulin shots <input type="radio"/> Diabetes pills <input type="radio"/> Both <input type="radio"/> Neither <input type="radio"/> Don't know Hearing Loss before age 40: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Vision Loss: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Obesity: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Lipodystrophy: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Cardiomyopathy/enlarged heart: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Lipid/fat/cholesterol disorder: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Kidney Problems: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Other autoimmune disorders: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

[BUTTON TO ADD ANOTHER BROTHER/SISTER ROW TO THE TABLE]

Do you have any biological children?

☐ Yes

☐ No

☐ Don't Know

Your Biological Children											
	Sex at Birth	Current Age (if alive; in years)	Age at Death (in years)	Cause of Death	Medical Conditions (Please indicate whether your family member had any of the medical conditions listed below by selecting Yes, No, or Don't Know next to the condition.)				Age when diagnosed in years (Estimate age, or leave blank if you don't know)	Other Diagnosed Medical Conditions and Age at Diagnosis (in years)	Do you think this family member might be interested in participating in this study?
					Condition	Yes	No	Don't Know			
Child #1	<input type="checkbox"/> Male <input type="checkbox"/> Female				Type 1 Diabetes: <input type="radio"/> Type 2 Diabetes: <input type="radio"/> Diabetes - Other/Unknown Type: <input type="radio"/> Diabetes Treatment: <input type="radio"/> Insulin shots <input type="radio"/> Diabetes pills <input type="radio"/> Both <input type="radio"/> Neither <input type="radio"/> Don't know Hearing Loss before age 40: <input type="radio"/> Vision Loss: <input type="radio"/> Obesity: <input type="radio"/> Lipodystrophy: <input type="radio"/> Cardiomyopathy/enlarged heart: <input type="radio"/> Lipid/fat/cholesterol disorder: <input type="radio"/> Kidney Problems: <input type="radio"/> Other autoimmune disorders: <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>  <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

[BUTTON TO ADD ANOTHER CHILD ROW TO THE TABLE]

Do you have any biological aunts or uncles on your Mom's Side (your biological mother's brothers and sisters)?

☐ Yes

☐ No

☐ Don't Know

Your Aunts and Uncles <u>on your Mom's Side</u> (Your biological mother's brothers and sisters)												
	Sex at Birth	Current Age (if alive; in years)	Age at Death (in years)	Cause of Death	Medical Conditions (Please indicate whether your family member had any of the medical conditions listed below by selecting Yes, No, or Don't Know next to the condition.)				Age when diagnosed in years (Estimate age, or leave blank if you don't know)	Other Diagnosed Medical Conditions and Age at Diagnosis (in years)	Is this person a full or half sibling of your biological mother?	Do you think this family member might be interested in participating in this study?
					Condition	Yes	No	Don't Know				
Aunt/ Uncle #1	<input type="checkbox"/> Male <input type="checkbox"/> Female				Type 1 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Full (same biological parents)	<input type="radio"/> Yes
					Type 2 Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Half: They have the same biological mother & different biological father.	<input type="radio"/> No
					Diabetes - Other/Unknown Type:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/> Half: They have the same biological father & different biological mother.	<input type="radio"/> Don't Know
					Diabetes Treatment:							
					<input type="radio"/> Insulin shots							
					<input type="radio"/> Diabetes pills							
					<input type="radio"/> Both							
					<input type="radio"/> Neither							
					<input type="radio"/> Don't know							
					Hearing Loss before age 40:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Vision Loss:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Obesity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Lipodystrophy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Cardiomyopathy/enlarged heart:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Lipid/fat/cholesterol disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Kidney Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
					Other autoimmune disorders:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

[BUTTON TO ADD ANOTHER MATERNAL AUNT/UNCLE ROW TO THE TABLE]



Do you have any biological aunts or uncles on your Dad's Side (your biological father's brothers and sisters)?

- ☐ Yes  
☐ No  
☐ Don't Know

Your Aunts and Uncles <u>on your Dad's Side</u> (Your biological father's brothers and sisters)									
	Sex at Birth	Current Age (if alive; in years)	Age at Death (in years)	Cause of Death	Medical Conditions (Please indicate whether your family member had any of the medical conditions listed below by selecting Yes, No, or Don't Know next to the condition.)	Age when diagnosed in years (Estimate age, or leave blank if you don't know)	Other Diagnosed Medical Conditions and Age at Diagnosis (in years)	Is this person a full or half sibling of your biological father?	Do you think this family member might be interested in participating in this study?
					Condition				
Aunt/ Uncle #1	<input type="checkbox"/> Male <input type="checkbox"/> Female				Type 1 Diabetes: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Type 2 Diabetes: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Diabetes - Other/Unknown Type: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Diabetes Treatment: <input type="radio"/> Insulin shots <input type="radio"/> Diabetes pills <input type="radio"/> Both <input type="radio"/> Neither <input type="radio"/> Don't know Hearing Loss before age 40: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Vision Loss: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Obesity: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Lipodystrophy: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Cardiomyopathy/enlarged heart: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Lipid/fat/cholesterol disorder: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Kidney Problems: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know Other autoimmune disorders: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know			<input type="radio"/> Full (same biological parents) <input type="radio"/> Half: Same biological mother; different biological father. <input type="radio"/> Half: Same biological father; different biological mother.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

[BUTTON TO ADD ANOTHER PATERNAL AUNT/UNCLE ROW TO THE TABLE]

[Submit]

[Save & Return Later]

**Family History Form Review Log:**

*After the initial completion of the Family History Form: Please complete the below table each time the participant's Family History Form is reviewed by the study staff and either updated or confirmed to still be accurate.*

Review Date	First and Last Name of staff member who reviewed the Family History Form	Were any changes made to the Family History Form?
____/____/____		<input type="radio"/> Yes <input type="radio"/> No

**[Add Another Review]**