GoKinD Study
Parents

Lab #:_____

Joslin Family #:_____

Name _____

Address _____

_____

_____

Joslin Study #:_____

GoKinD ID #:_____

PTMR_____

Male_____ **Female**_____

Proband _____

Relation to Proband _____

Initials:_____

Birth Date ____/____/____

Phone Number (home) _____

(work*) _____

Today's Date ____/____/____

optional *– only if you wish to be contacted at work*

E-mail Address (optional)_____

Medical History

1. Do you have diabetes? NO_____ YES____

IF YES, Please give the year of diagnosis of your diabetes: year _____

IF YES, What is your current treatment? none _____ diet _____ oral agents _____ insulin _____

IF ON INSULIN, when did you start insulin therapy? year _____

IF ON INSULIN, what is your current regimen?

<2 shots _____ MDI _____

Pump _____ Other _____

IF ON INSULIN, what is your current daily dose? _____ Units

2. Has a doctor ever said that you have high blood pressure or hypertension?

NO _____ YES_____

IF YES, please specify year of first diagnosis YEAR_____

3. Have you ever had a heart attack? NO _____ YES _____

IF YES, please indicate year of first heart attack YEAR _____

Have you ever been hospitalized due to a heart attack? NO _____ YES _____

IF YES, please indicate year of first heart attack hospitalization YEAR _____

Have you ever had coronary bypass surgery? NO _____ YES _____

IF YES, please indicate year of first bypass surgery YEAR _____

Have you ever had angioplasty? NO _____ YES _____

IF YES, please indicate year of first angioplasty YEAR _____

Have you ever had a stroke or TIA (transient ischemic attack)? NO _____ YES _____

IF YES, please indicate year of first stroke/TIA YEAR _____

4. Has a doctor ever said that you have retinopathy or eye problems related to diabetes?

NO _____ YES _____

IF YES, please specify and indicate year of first diagnosis or treatment (if applicable):

DIAGNOSIS	Yes/No	Year
Non-Proliferative Retinopathy		
Proliferative Retinopathy		
Laser Treatment		
Other		

IF LASER TREATMENT IS YES, what was the laser treatment for:

Retinopathy _____ Macular Edema _____ Unknown _____

IF OTHER, please specify diagnosis:

_____

_____

_____

5. Has a doctor ever said that you have kidney disease (nephropathy) ***related to diabetes***?

NO _____ YES _____

IF YES, please specify and indicate year of diagnosis or treatment (if applicable):

DIAGNOSIS	YES/NO	Year
Microalbuminuria		
Proteinuria		
1st Dialysis		
1st Renal Transplant		
2nd Dialysis		
2nd Renal Transplant		
3rd Dialysis		
3rd Renal Transplant		

IF YOU HAVE HAD A KIDNEY TRANSPLANT,

Was it part of a simultaneous pancreas / kidney transplant? NO _____ YES _____

6. Has a doctor ever said you have kidney disease that is ***NOT related to diabetes***?

   NO _____ YES _____

   IF YES, please explain:

   _____

   _____

   _____

7. Have you had any of the following Autoimmune diseases?

Autoimmune Disease	Yes/No
Addison's disease	
Ulcerative Colitis	
Crohn's Disease	
Systemic Lupus Erythematosus	
Rheumatoid Arthritis	
Juvenile Rheumatoid Arthritis	
Multiple Sclerosis	
Celiac Sprue	
Grave's Disease (Hyperthyroid)	
Hashimoto's Disease (Hypothyroid)	
Pernicious Anemia	
Vitiligo	
Alopecia	
Other	

8. Have you had any other diseases, illnesses, or complications? NO ___ YES ___

IF YES, please specify_____

_____

_____

_____

_____

_____

Medication

9. Please list all of your current medications below:

Medication Names	

Please provide information about current and past usage of ACE-inhibitors (if not already listed)
* See attached list of common ACE-inhibitors

Medication name*	Year began	Year Ended (if Not currently Used)	Dose

Please provide information about current usage of other blood pressure medications (if not already listed)

Medication name

Are you currently taking aspirin regularly? NO _____ YES _____

Are you currently taking NSAIDs regularly? (e.g. Motrin, ibuprofen, Nuprin) NO _____ YES _____

Are you currently taking vitamin E regularly? NO _____ YES _____

ORIGIN

10. Because the incidence of renal complications varies among different populations, please indicate the population you consider yourself to be a member of: (optional)

_____ American Indian or Native American
_____ Asian or Pacific Islander
_____ Black, not of Hispanic Origin
_____ Hispanic
_____ White, not of Hispanic Origin
_____ Other or Unknown

Please indicate the ethnic origin of your father? _____

Please indicate the ethnic origin of your mother? _____

Please indicate the birthplace of your father (city, country, or region)? _____

Please indicate the birthplace of your mother (city, country, or region)? _____

Thank You!

List of common ACE-inhibitors

Accupril (Quinapril)

Aceon (Peridopril)

Altace (Ramipril)

Avapro (Irbesartan)

Capoten (Captopril)

Capozide (Captoril + HCT)

Cozaar (Losartan)

Diovan (Valsartan)

Hyzaar (Losartan + HCT)

Lexxel (Elanapril + Felodipine)

Lotensin (Benazepril)

Lotensin HCT (Benazepril + HCT)

Lotrel (Amlodipine + Benazepril)

Mavik (Trandolapril)

Monopril (Fosinopril)

Prinivil (Lisinopril)

Prinzide (Lisinopril + HCT)

Tarka (Trandolapril + Verapimil)

Uniretic (Moexipril + HCT)

Univasc (Moexipril)

Vaseretic (Elanapril + HCT)

Vasotec (Elanapril)

Zestoretic (Lisinopril + HCT)

Zestril (Lisinopril)