

## Checklist for Proband/Relatives

This checklist is to be completed by a staff person during the phone call to the proband or relative (parent). It is a guideline to be used to obtain information from volunteers on their status regarding complications of diabetes and their willingness to go to the nearest GoKinD clinic. If the date, time, month or number of months is unknown, use 00. Complete the entire checklist for each person called, regardless of the information you learn. Send original to the COC in the GoKinD mailing.

### A. IDENTIFYING INFORMATION

1. Clinic Number: Clinic \_\_\_\_\_
2. Family ID Number: Family \_\_\_\_\_
3. Proband/Relative Code: Relcode \_\_\_\_\_
4. Proband/Relative Initials: Relinit \_\_\_\_\_  
F M L
5. Proband/Relative Birthdate: Bodobdt \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year
6. Date of this contact: Boformdt \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year
7. Gender: Bosex Male (1) Female (2)
8. Predominant Race/Ethnicity: (Check only one.) Borace
  - White, not of Hispanic Origin (1)
  - Black, not of Hispanic Origin (2)
  - Hispanic (3)
  - Asian or Pacific Islander (4)
  - American Indian or Alaskan Native (5)
  - Other (6)

a) If other, specify: Borace1 \_\_\_\_\_
9. Is the proband/ relative a twin? Botwin NO (1) YES (2)
  - a) If YES, is the twin identical? Botwin1 (1) (2)

**Botwin2**

b) Please indicate the proband/Relative Code of the twin: \_\_\_\_\_

### B. DIABETES HISTORY (brief): Complete this section for all probands. [If relative does not have diabetes, go to H]

1. What date was diabetes diagnosed? Bdiabdt \_\_\_\_\_/\_\_\_\_/\_\_\_\_ Unknown (3)  
Mo Yr
2. Have you ever taken oral drugs for diabetes? Booral1 NO (1) YES (2)
  - a) If YES, are you currently taking oral drugs? Booral2 (1) (2)
  - b) If NO, when did you stop taking oral agents? Booral3 \_\_\_\_\_/\_\_\_\_/\_\_\_\_ Unknown (3)  
Mo Yr
3. Are you currently taking insulin? Boinsul1 NO (1) YES (2)
  - a) If YES, what is your current regimen of insulin? (answer one): Boinsul2
    - < 2 Shots (1) Pump (3)
    - MDI (2) Other (4)

b) If other, specify: Boinsul3 \_\_\_\_\_
4. When did you begin uninterrupted use of insulin? Boinsul4 \_\_\_\_\_/\_\_\_\_/\_\_\_\_ Unknown (3)  
Mo Yr
5. What is your current total daily dose of insulin? Boinsul5 \_\_\_\_\_ units
6. Are you currently taking oral drugs and insulin? Boinsul6 NO (1) YES (2)
7. Number of episodes of DKA requiring hospitalization in the past YEAR: Bohosp1 \_\_\_\_\_

Family ID: \_\_\_\_\_

Proband/ Relative Code: Bohosp2

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8. Number of hospitalizations for hypoglycemia in past YEAR: \_\_\_\_\_

(Hospitalization implies overnight admission to the hospital; an emergency ward visit that did not result in hospitalization does not apply.)

9. How many times during the past YEAR did the volunteer experience hypoglycemia of such severity that the volunteer: Bohypgl1a) Lost consciousness without seizure Bohypgl2

b) Lost consciousness with seizure \_\_\_\_\_

10. On the average, how many times per day does the volunteer monitor his/her blood for glucose? (IF ZERO, WRITE 00) Boglucch \_\_\_\_\_11. Does the volunteer adjust his/her insulin dose based on the results of self blood glucose monitoring? Boinsadj NO YES  
(1) (2)**C. EYE COMPLICATIONS**

Have you ever been told by a health care professional that you have or had:

		NO	YES	UNKNOWN
1. Any diabetes related eye problems?	<u>Boeye1</u>	(1)	(2)	(3)
a) If YES, specify:	<u>boeye2</u>			
2. Laser Treatment for retinopathy?		NO	YES	UNKNOWN
a) Focal Laser Treatment for macular edema	<u>Boeye4</u>	(1)	(2)	(3)
1) Year of First Treatment:	<u>Boeye4a</u>	_____		
b) Pan-retinal Laser Treatment for retinopathy	<u>Boeye5</u>	(1)	(2)	(3)
1) Year of First Treatment:	<u>Boeye5a</u>	_____		
3. Impairment of vision?	<u>Boeye6</u>	(1)	(2)	(3)
4. Cataracts?	<u>Boeye7</u>	(1)	(2)	(3)
5. Detached retina?	<u>Boeye8</u>	(1)	(2)	(3)

**D. KIDNEY COMPLICATIONS**

Have you ever been told by a health care professional that you have or had:

		NO	YES	UNKNOWN
1. Diabetic kidney problems?	<u>Bokidn1</u>	(1)	(2)	(3)
2. Protein or albumin in the urine?	<u>Bokidn2</u>	(1)	(2)	(3)
a) Year of first protein or albumin in the urine:	<u>Bokidn3</u>	_____		

3. Have you ever had kidney dialysis? Bodial NO YES UNKNOWN  
If yes: (1) (2) (3)a) 1<sup>st</sup> Kidney dialysis? Bodial1 (1) (2) (3)b) What year? Bodial2 \_\_\_\_\_c) 2<sup>nd</sup> Kidney dialysis? Bodial3 (1) (2) (3)d) What year? Bodial4 \_\_\_\_\_e) 3<sup>rd</sup> Kidney dialysis? Bodial5 (1) (2) (3)f) What year? Bodial6 \_\_\_\_\_4. Have you ever had a kidney transplant? Botrans (1) (2) (3)  
If YES:a) 1<sup>st</sup> Kidney transplant? Botrans1 (1) (2) (3)b) What year? Botrans2 \_\_\_\_\_c) 2<sup>nd</sup> Kidney transplant? Botrans3 (1) (2) (3)d) What year? Botrans4 \_\_\_\_\_e) 3<sup>rd</sup> Kidney transplant? Botrans5 (1) (2) (3)f) What year? Botrans6 \_\_\_\_\_5. Have you ever had a pancreas transplant? Bopancr (1) (2) (3)  
If yes:a) 1<sup>st</sup> Pancreas transplant? Bopancr1 (1) (2) (3)b) What year? Bopanc2 \_\_\_\_\_**E. CARDIOVASCULAR COMPLICATIONS**

Have you ever been told by a health care professional that you have or had:

		NO	YES	UNKNOWN
1. Any problems with heart or blood vessels?	<u>Boheart1</u>	(1)	(2)	(3)
a) If YES, specify:	<u>Boheart2</u>			

Have you ever been hospitalized for: NO YES UNKNOWN

2. Heart pains or angina? Boheart3 (1) (2) (3)3. Heart attack or myocardial infarction? Boheart4 (1) (2) (3)a) Year of first myocardial infarction: Boheart5 \_\_\_\_\_

Family ID: \_ \_ \_ \_ \_

Proband/ Relative Code: \_ \_ \_  
NO YES UNKNOWN

4. Coronary bypass surgery or angioplasty? **Boheart6** (1) (2) (3)  
a) Year of first surgery or angioplasty: **Boheart7** \_ \_ \_ \_ \_
5. Stroke/TIA? **Bostrok1** (1) (2) (3)  
a) Year of first event: **Bostrok2** \_ \_ \_ \_ \_
6. High blood pressure? **Bohprt1** (1) (2) (3)
7. Drug treatment for high blood pressure or hypertension? **Bohprt2** (1) (2) (3)  
a) If YES, are you currently receiving drug treatment? **Bohprt3** (1) (2) (3)

**F. NEUROPATHY**

Have you ever been told by a health care professional that you have or had: NO YES UNKNOWN

1. Neuropathy (nerve damage) due to diabetes? **Boneurp1** (1) (2) (3)
2. Do you have a tingling in your arms or legs? **Boneurp2** (1) (2) (3)
3. Are you unable to feel your feet when you walk? **Boneurp3** (1) (2) (3)

**G. PERIPHERAL VASCULAR COMPLICATIONS**

Have you ever been told by a health care professional that you have or had: NO YES UNKNOWN

1. Any trouble with circulation in legs? **Bopvc1** (1) (2) (3)
2. Foot ulcers? **Bopvc2** (1) (2) (3)
3. Gangrene? **Bopvc3** (1) (2) (3)

Have you ever had:

4. Non-traumatic amputation? **Bopvc4** (1) (2) (3)

**H. AUTOIMMUNE DISEASES**

Have you ever been told by a health care professional that you have or had:

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NO YES UNKNOWN

1. Addison's disease **Boad-ad** (1) (2) (3)
2. Ulcerative colitis **Boad-uc** (1) (2) (3)
3. Crohn's disease **Boad-cd** (1) (2) (3)
4. Systemic lupus erythematosus **Boad-sle** (1) (2) (3)
5. Rheumatoid arthritis **Boad-ra** (1) (2) (3)
6. Juvenile rheumatoid arthritis **Boad-jra** (1) (2) (3)
7. Multiple sclerosis **Boad-ms** (1) (2) (3)
8. Celiac sprue **Boad-cs** (1) (2) (3)
9. Grave's disease (Hyperthyroid) **Boad-gd** (1) (2) (3)
10. Hashimoto's disease (Hypothyroid) **Boad-hd** (1) (2) (3)
11. Pernicious anemia **Boad-pa** (1) (2) (3)
12. Vitiligo (depigmentation) **Boad-v** (1) (2) (3)
13. Alopecia (baldness) **Boad-a** (1) (2) (3)
14. Other **Boad-oth1** (1) (2) (3)

a) If other, specify: \_\_\_\_\_

**I. OTHER MAJOR MEDICAL DISEASES**

1. Do you have any serious medical problems not mentioned yet? **Boother** NO YES UNKNOWN  
(1) (2) (3)

a) Specify: **Boother1** \_\_\_\_\_

CONTINUE TO NEXT PAGE

Family ID: \_\_\_\_\_

Proband/ Relative Code: \_\_\_\_

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## J. WILLINGNESS TO PARTICIPATE

Explain that the next step is to schedule an appointment for the clinical assessments and discuss what time commitment would be necessary. Reiterate general information about the examination. Determine the location of the nearest GoKinD center to this person.

1. How far do you live from the nearest GoKinD clinic? Bolive \_\_\_\_\_ miles

2. Would you have transportation problems getting to a GoKinD center? Botran1 NO YES  
(1) (2)

a) Specify: Botran2

3. Will you agree to come to the GoKinD clinic located in: Boagree1 NO YES UNCERTAIN  
Boagree3 (1) (2) (3)  
for the examinations?

a) If NO, would alternative arrangements be acceptable to you? Boagree2 NO YES UNCERTAIN  
(1) (2) (3)

1. Yes, if remote site Boagree4 (1) (2)

2. Yes, if CTI Boagree5 (1) (2)

Name of person completing this form:

4. What times are most convenient for you to come to the center?

Boconv  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What times will it be impossible for you to come to the center?

Boimpos  
\_\_\_\_\_  
\_\_\_\_\_

Certification No. (if any) Bocert

\_\_\_\_ - \_\_\_\_ - \_\_\_\_