Form 005a.10
3/29/01

GoKinD Study
Diabetic Offspring

Lab #: ***LABNO***

Joslin Family #:_____

Joslin Study #:_____

GoKinD ID #: ***GK_ID***

PTMR_____

Name _____

Address _____

_____

_____

Male ***__1__*** **Female** ***__2__*** ***SEX***

Proband _____

Relation to Proband _____

Initials ***INITIALS***

Birth Date ***DOB***

Phone Number (home) _____

Today's Date ***EXAMDATE***

(work*) _____

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

E-mail Address (optional)_____

Medical History

1. Do you have diabetes? NO YES ***DIAB***

2. **IF NOT DIABETIC**, Have you ever had diabetes treated by a pancreas transplant? NO YES ***PANTX***

IF YES TO TRANSPLANT, Please give the year the transplant was performed: year ***PANTXYR***

IF YES TO EITHER 1 or 2, Please give the year of diagnosis of your diabetes: year ***DM_YR***

IF YES TO EITHER 1 or 2, What is your current treatment (or treatment at the time or transplant)?

none ***NONE*** diet ***DIET*** oral agents ***ORAL*** insulin ***INSLN***

IF INSULIN, when did you start insulin therapy? year ***INS_YR***

IF INSULIN, what is your current regimen? ***REGIMEN***

<2 shots ____***1***____ MDI _____***2***___

Pump ____***3***____ Other _____***4***___

IF INSULIN, what is your current daily dose (or daily dose at time or transplant)?

UNITS Units

IF YOU HAVE DIABETES, do you check your blood sugar levels at home? NO YES ***GLUCHOME***

IF YES, how many times a day do you usually check your own blood sugar? ***GLUCCHK***

<1 __***0***__ 1 __***1***__ 2 ___***2***__ 3 ___***3***__ 4+ ___***4***__

IF YES, do you adjust your insulin dose based on your blood sugar level? NO YES ***ADJUST***

IF YES, at what blood sugar do you feel your best? ***GLUCBEST***

IF YES How often, when checked, are you in that range? ***GLUCFREQ***

___***1***____ Less than ½ the time ___***2***____ About ½ the time ____***3***___ More than ½ the time

3. Has a doctor ever said that you have high blood pressure or hypertension? NO YES ***HYPRT***

IF YES, please specify year of first diagnosis YEAR ***HYPRTYR***

4.

		IF YES, PLEASE INDICATE YEAR
Have you ever had a heart attack?	NO	YES ***HEART*** YEAR ***HRTYR***
Have you ever been hospitalized due to a heart attack?	NO	YES ***HRTHOSP*** YEAR ***HRTHOSPYR***
Have you ever had coronary bypass surgery?	NO	YES ***BYPASS*** YEAR ***BYPASSYR***
Have you ever had angioplasty?	NO	YES ***ANGIO*** YEAR ***ANGIOYR***
Have you ever had a stroke or TIA (transient ischemic attack)?	NO	YES ***STROKE*** YEAR ***STROKEYR***

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

NO YES ***RETINO***

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

DIAGNOSIS	Yes/No	Year
Non-Proliferative Retinopathy	***NPRET***	***NPRETYR***
Proliferative Retinopathy	***PRORET***	***PRORETYR***
Laser Treatment	***LASER***	***LASERYR***
Other	***OTRET***	***OTRETYR***

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

Retinopathy ____***1***_____ Macular Edema _____***2***_____ Unknown _____***3***_____

IF OTHER, please specify diagnosis: ***OTRETSPEC***

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

NO YES ***RENAL***

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

DIAGNOSIS	Yes/No	Year
Microalbuminuria		
Proteinuria		
1st Dialysis	***DIAL***	***DIALYR***
1st Renal Transplant	***TRANS***	***TRANSYR***
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 ***SPK***

6. Has a doctor ever said you have kidney disease that is ***NOT related to diabetes***? NO YES ***KIDOTH***

IF YES, please explain: ***KIDOTHSPEC***

_____

_____

_____

7. Has a doctor ever said that you have Peripheral Vascular Disease related to diabetes? NO YES ***PVD***

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

DIAGNOSIS	Yes/No	Year
Claudication	***CLAUD***	***CLAUDYR***
Non-traumatic Amputation	***AMPUT***	***AMPUTYR***
Foot Ulcers	***FTULCER***	***FTULYR***
Gangrene	***GANG***	***GANGYR***

8. Have you ever experienced tingling in your feet, hands or legs? NO YES ***TINGLE***

Have you ever experienced numbness in your feet, hands or legs? NO YES ***NUMB***

Has a doctor ever said that you have nerve damage due to diabetes? (neuropathy) NO YES ***NEURO***

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

AUTOIMMUNE DISEASE	Yes/No
Addison's disease	***AD_AD***
Ulcerative Colitis	***AD_UC***
Crohn's Disease	***AD_CD***
Systemic Lupus Erythematosus	***AD_SLE***
Rheumatoid Arthritis	***AD_RA***
Juvenile Rheumatoid Arthritis	***AD_JRA***
Multiple Sclerosis	***AD_MS***
Celiac Sprue	***AD_CS***
Grave's Disease (Hyperthyroid)	***AD_GD***
Hashimoto's Disease (Hypothyroid)	***AD_HD***
Pernicious Anemia	***AD_PA***
Vitiligo	***AD_V***
Alopecia	***AD_A***
Other	***AD_OT***

10. Have you had any other diseases, illnesses, or complications? NO YES ***OTHERDIS***

IF YES, please specify ***DISSPEC***

Medication

12. Please list all of your current medication below:

ACE_M

ACE_M2

ACE_M3

AHTN_M

AHTN_M2

AHTN_M3

DIUR_M

DIUR_M2

HART_M

HART_M2

LIP_M

GAST_M

PSYC_M

THYR_M

HORM_M

OTHER_M1

OTHER_M2

OTHER_M3

OTHER_M4

OTHER_M5

Are you currently taking aspirin regularly? NO YES ***ASPR***

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

Are you currently taking vitamin E regularly? NO YES ***VITE***

Cigarette Smoking

13. Have your ever smoked cigarettes? NO YES ***SMOKE***

IF NO, please skip the rest of the smoking questions.

IF YES, how old were you when you first started smoking regularly? AGE ***SMOKEAGE***

14. Do you smoke cigarettes now? NO YES ***CURSMOKE***

IF NO, how old were you when you last smoked regularly? AGE ***LSTSMOKE***

On average, how many PACKS of cigarettes did you smoke per day during the last month that you smoked regularly? ***PASTPPD***

___*1*___ less than ½ PACK ___*2*___ ½ to 1 PACK

___*3*__ more than 1, but less than 2 PACKS ___*4*___ 2 or more PACKS

IF YES, how many PACKS of cigarettes do you smoke per day? ***CURPPD***

___*1*___ less than ½ PACK ___*2*___ ½ to 1 PACK

___*3*__ more than 1, but less than 2 PACKS ___*4*___ 2 or more PACKS

Family History

Please complete the following regarding your family's health history

15. PARENTS

	YEAR OF BIRTH	**DIABETES?** NO **YES**	**AGE OF ONSET**	HIGH BLOOD PRESSURE? NO YES	LIVING? NO YES	IF DECEASED, YEAR OF DEATH
FATHER	***FYOB***	***FDIAB***	***FDIABAGE***	***FHBLD***	***FLIV***	***FYOD***
MOTHER	***MYOB***	***MDIAB***	***MDIABAGE***	***MHBLD***	***MLIV***	***MYOD***

We may want to contact your parents to assist us with our research, please indicate their names, addresses, and telephone numbers in the following table.

	NAME	ADDRESS	PHONE NUMBER
FATHER			
MOTHER			

16. SISTERS / BROTHERS

Do you have any brothers or sisters? NO_____ YES_____

IF YES, please list your brothers and sisters by year of birth and complete the following table.

Sib	Year of birth	Sex M/F	Diabetes Y/N	Diabetes Age of onset	Diabetes treatment (none, diet, oral, insulin)	Kidney disease Y/N	Living Y/N
1	***SIB#YOB***	***SIB#GEND***	***SIB#DM***	***SIB#AGE***	***SIB#TX***	***SIB#KID***	***SIB#LIV***
2							
3							
4							
5							
6							
7							
8							

Number of siblings ***SIB_NO***

Number of diabetic siblings ***SIB_DM***

If any of your brothers or sisters also have diabetes, we may want to contact him/her/them to assist us with our research. Please indicate their names, addresses, and telephone numbers in the following table.

SIB#CON

Sib	Year of birth	Name	Address	Phone
1				
2				
3				

17. If we would like to contact other siblings in the future, would you be willing to help us locate them?

NO YES ***HELP***

ORIGIN

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

ORIGIN

__*5*___ American Indian or Native American
__*4*___ Asian or Pacific Islander
__*2*___ Black, not of Hispanic Origin
__*3*___ Hispanic
__*1*___ White, not of Hispanic Origin
__*6*___ Other or Unknown

Please indicate the ethnic origin of your father? ***FETH***
Please indicate the ethnic origin of your mother? ***METH***

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

Thank You!

ACR_DATE	Date of ACR from Medical Record
ACR_MR	ACR value from Medical Record
ACR_PROT	Flag if no ACR value, but ALBUSTX = 2+ (date will still be entered)
ACR_ESRD	Flag if no ACR value because subject has ESRD (date will be left blank)
ACR_NO_HIST	Flag if no ACR value, USCR1 collected from patient
CC	Subjects recruited as a Case or Control

Study Status

Name of Subject:_____ Family number:_____

Name of Proband:_____ Study number:_____

Relationship of Subject to Proband:_____ Lab number:_____

PROCEDURE	DATE	NOTES
Consent Form		
Questionnaire		
Lab: blood urine		
Results and thank you		
Samples sent to MN: blood urine		
Misc. voucher submitted		
Entered into database		

MEASUREMENT	DATE	NOTES
Blood Pressure # 1 (sys/dia) ***SYS1/DIA1***		
Blood Pressure # 2 (sys/dia) ***SYS2/DIA2***		
Height: ***HEIGHT*** *inches*		
Weight: ***WGHT*** *lbs.*		
Time of urine void: ***VOID***		
Time of last meal: ***MEAL***		
Time of blood draw: ***DRAW***		
Blood glucose: ***BLDGLUC***		