MEDICAL HISTORY (MH)

Chronic Kidney Disease in Children (CKiD)

SECTION A: GENERAL INFORMATION

Ccc PARTICIPANT ID: AFFIX ID LABEL OR ENTER NUMBER IF ID LABEL IS NOT AVAILABLE

|__| - |__|__| - |__|__|__|

A2. CKiD VISIT #: 0 1 a

A3. FORM VERSION: 0 1 / 0 1 / 0 7

A4. DATE OF VISIT: ___ ___/ ___ ___/ ___ ___ ___ ___
M M D D Y Y Y Y

A5. INTERVIEWER'S INITIALS: ___ ___ ___

For each question, fill in the answer or circle the number that best matches the respondent's answer. Circle -8 for "Don't Know" responses. If a participant declines to answer a question, document -7 to the right of the response choice(s). For missing data, document -9 to the right of the response choice(s). Please document the reason for missing data (i.e., the question was accidentally skipped.)

Read each question and follow skip patterns as they appear on the form. Review the QxQ for detailed descriptions of questions.

INTRODUCTION TO PARTICIPANT:

Now, I am going to ask you questions about your child's health history. I will be asking you a series of questions about the current and past diseases that your child may have had in life. Dates may be hard to remember. Please take as much time as you need so I can gather information that is as accurate as possible.

If at any point in the interview you want me to stop, let me know. Finally, I need to re-emphasize that all your answers are confidential, and the responses you provide will in no way affect your child's clinical care. The first set of questions asks about your child's kidney disease. Throughout the questionnaire, I am going to use the words "health care provider" to mean any doctor, nurse, physician assistant or nurse practitioner the child has ever seen. If you have trouble understanding anything I say, stop me and I will re-read the question.

SECTION B: KIDNEY DISEASE

B1. When did the mother or another family member first become aware of (*name of child*) kidney problem?

During Pregnancy..... 1 **(Skip to B4)**

After Pregnancy..... 2

Don't Know..... -8

B3. How old was (*name of child*) when you or another family member first became aware of his/her kidney problem?
(Please circle "1" for years, "2" for months, "3" for weeks or "4" for days.)

age ___ ___

1 = years
2 = months
3 = weeks
4 = days

Don't Know..... -8

B4. How old was (*name of child*) when he or she was first seen by a pediatric nephrologist?
(Please circle "1" for years, "2" for months, "3" for weeks or "4" for days.)

age ___ ___

1 = years
2 = months
3 = weeks
4 = days

Don't Know..... -8

B5. Has *(name of child)* been seen by a Urologist (adult or pediatric)?

Yes..... 1

No..... 2 **(Skip to B6)**

a. How old was (*name of child*) when he or she was first seen by a Urologist (adult or pediatric)?
(Please circle "1" for years, "2" for months, "3" for weeks or "4" for days.)

age ___ ___

1 = years
2 = months
3 = weeks
4 = days

Don't Know..... -8

B6. What were the methods/procedures performed to determine the **primary** diagnosis of *(name of child)* with chronic kidney disease?

(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)

		Yes	No	Don't Know
a.	Kidney Biopsy.....	1	2	-8
b.	Ultrasound/sonogram.....	1	2	-8
c.	Voiding Cystourethrogram (VCUG)	1	2	-8
d.	Nuclear Medicine Study (i.e., DMSA, DTPA, MAG3) ...	1	2	-8
e.	Intravenous Pyelogram (IVP)	1	2	-8
f.	Magnetic Resonance Imaging (MRI)	1	2	-8
g.	Computed Tomography Scan (Cat/CT Scan)	1	2	-8
h.	Genetic Testing.....	1	2	-8
i.	Other.....	1	2	-8
			(Skip to B7)	**(Skip to B7)**

1. Specify Other method/procedure: _____

PROMPT: IF ANY OF B7 – B8 = YES, THEN COMPLETE THE MEDICAL ABSTRACTION TRACKING FORM (MAT).

B7. Has (*name of child*) ever had a urologic procedure, including surgery to treat his or her kidney problems?

Yes ..... 1 **(Complete MAT)**
No 2
Don't Know ..... -8

B8. Has (*name of child*) ever had a genetic test (i.e., Podocin or Nephrin) performed to help diagnose his or her kidney disease?

Yes ..... 1 **(Complete MAT)**
No 2
Don't Know ..... -8

B9. Has a healthcare provider ever diagnosed (*name of child*) with a kidney infection with a fever?

Yes 1
No ..... 2 **(Skip to B10)**
Don't Know ..... -8 **(Skip to B10)**

a. How many times did he/she have a kidney infection with a fever in his/her first year of life?

___ ___ times

Don't Know..... -8

b. How many times did he/she have a kidney infection with a fever during the last year?

___ ___ times

Don't Know..... -8

B10. Is participant a female?

Yes..... 1

No..... 2 **(Skip to C1)**

B11. Has (*name of child*) started her menses (i.e. period)?

Yes..... 1

No..... 2 **(Skip to C1)**

Don't Know..... -8 **(Skip to C1)**

a. How old was she when she started her menses (i.e. period)?

___ ___ years

Don't Know..... -8

SECTION C: GENERAL MEDICAL HISTORY

The next set of questions asks about diseases, other than kidney disease, that your child may currently have or that your child has had since birth.

Has a doctor or any other healthcare professional ever told you that (*name of child*) has any of the following diseases?

PROMPT: IF ANY OF C1 – C4 = "YES", THEN COMPLETE THE MEDICAL ABSTRACTION TRACKING FORM (MAT).

(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)

	Yes	No	Don't Know
C1. GENERAL / METABOLIC DISEASE			
a. Diabetes Mellitus (Sugar Diabetes, High Blood Sugar)	1	2	-8
b. Sickle Cell Disease	1	2	-8
c. Auto-immune Disease (Lupus, Rheumotid Arthritis)	1	2	-8
C2. CARDIOVASCULAR DISEASE			
a. Hypertension (High blood pressure)	1	2 **(Skip to b)**	-8 **(Skip to b)**
i. If hypertensive, what is the status? Continued problem…… 1 Resolved problem……..... 2 Controlled with medication…… 3			
b. Heart Failure (Congestive heart failure)	1	2	-8
c. Stroke	1	2	-8
C3. LUNG DISEASE			
a. Asthma	1	2	-8
b. Chronic Lung Disease	1	2	-8
c. Bronchopulmonary Dysplasia (BPD)	1	2	-8
C4. GENITOURINARY DISEASE			
a. Urinary Tract Infection	1	2	-8
C5. INFECTIOUS DISEASE			
a. Hepatitis	1	2 **(Skip to C5b)**	-8 **(Skip to C5b)**
1. If yes, has a doctor or any other healthcare professional ever told you that (name of child) has had any of the following types of hepatitis?			
i. Type A	1	2	-8
ii. Type B	1	2	-8
iii. Type C	1	2	-8
iv. Other Type(s)	1	2 **(Skip to C5b)**	-8 **(Skip to C5b)**
Specify:_____			
b. Other Infection(s)	1	2 **(Skip to C6)**	-8 **(Skip to C6)**

Specify:_____

(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)

		Yes	No	Don't Know
C6.	NEUROPSYCHIATRIC DISEASE			
a.	Attention Deficit Disorder (ADD)	1	2	-8
b.	Attention Deficit Hyperactivity Disorder (ADHD)	1	2	-8
c.	Depression	1	2	-8
d.	Learning Disability other than ADD or ADHD	1	2	-8
e.	Anxiety Disorder	1	2	-8
f.	Other	1	2 **(Skip to C7)**	-8 **(Skip to C7)**
	Specify:_____			

		Yes	No	Don't Know
C7.	CHILDHOOD ILLNESSES			
a.	Measles	1	2	-8
b.	German Measles	1	2	-8
c.	Mumps	1	2	-8
d.	Chickenpox	1	2	-8
e.	Tuberculosis	1	2	-8
f.	Whooping Cough	1	2	-8
g.	Scarlet Fever	1	2	-8
h.	Rheumatic Fever	1	2	-8
i.	Diphtheria	1	2	-8
j.	Meningitis	1	2	-8
k.	Encephalitis	1	2	-8
l.	Anemia	1	2	-8
m	Fever above 104° for greater than 2 days	1	2	-8
n.	Head injury	1	2	-8
o.	Coma or loss of consciousness	1	2	-8

Please indicate whether (*name of child*) has or has had any of the following problems.
(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)

		Yes	No	Don't Know
C8.	NEUROLOGICAL			
	a. Seizures/Convulsions	1	2	-8
	b. Speech Defects	1	2	-8
	c. Accident Prone	1	2	-8
	d. Bites Nails	1	2	-8
	e. Sucks Thumb	1	2	-8
	f. Grinds Teeth	1	2	-8
	g. Twitches/Tics	1	2	-8
	h. Bangs Head	1	2	-8
	i. Rocks Back and Forth	1	2	-8
	j. Bowel Movements in Bed/Pants	1	2	-8
C9.	HEARING			
	a. Ear Infections	1	2	-8
	b. Hearing Problems	1	2	-8
	c. Ear Tubes	1	2	-8
C10.	VISION			
	a. Vision Problems	1	2	-8
	b. Wears Glasses/Contacts	1	2	-8
	c. Color Blindness	1	2	-8

SECTION D: ORTHOPEDIC HISTORY

The next set of questions asks about any orthopedic injuries your child may currently have or that your child has had since birth. Orthopedic injuries are injuries to the bones.

		Yes	No	Don't Know
D1.	Has a doctor or any other health professional ever told you that (name of child) has had any broken bones?	1	2 **(Skip to E1)**	-8 **(Skip to E1)**

a. Please indicate which of the following bones (name of child) has broken.
(Please circle "Yes", "No" or "Don't Know" for EACH of the following.)

		Yes	No	Don't Know
1.	Skull.....	1	2	-8
2.	Neck.....	1	2	-8
3.	Back.....	1	2	-8
4.	Shoulder.....	1	2	-8
5.	Arm/Elbow.....	1	2	-8
6.	Wrist/Hand.....	1	2	-8
7.	Hip.....	1	2	-8
8.	Knee.....	1	2	-8
9.	Ankle.....	1	2	-8
10.	Foot.....	1	2	-8
11.	Leg.....	1	2	-8
12.	Fingers.....	1	2	-8
13.	Toes.....	1	2	-8
14.	Ribs.....	1	2	-8
15.	Collar Bone……	1	2	-8

SECTION E: NUTRITIONAL ASSESSMENT

The next set of questions asks about your child's appetite and use of a nasogastric tube or gastrostomy tube. A nasogastric tube (NG tube) is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. A gastrostomy tube or button (GT) is a tube that directly enters the stomach.

E1. During the past week, how would you rate (*name of child*) appetite? Please circle one choice.

Very Good..... 1
Good..... 2
Fair..... 3
Poor..... 4
Very Poor..... 5

E2. Does (*name of child*) use a gastrostomy tube/button or Nasogastric tube (NG tube) for nutritional purposes?

Yes..... 1
No..... 2 **(Skip to E3)**
Don't Know..... -8 **(Skip to E3)**

a. In the past 12 months, how many months has the gastrostomy tube/button or NG tube been used?

___ ___ months

Don't Know..... -8

E3. In a 24 hour time period, does (*name of child*) take any nutritional supplement either by mouth, bottle or feeding tube?

Yes..... 1
No..... 2 **(Skip to F1)**
Don't Know..... -8 **(Skip to F1)**

Please use the following table to record the type and amount of any nutritional supplement or formula the child usually takes in a <u>24 hour period of time</u>. This should include supplement or formula taken by mouth, bottle or feeding tube.

START MHs1

	a) Name of Formula or Supplement (Ex: Similac PM 60/40, Enfamil LIPIL, Suplena, PediaSure, Nepro)	**Amount of Formula** (For pre-made liquid, use cans or ounces; if made from powder, use teaspoons, tablespoons or cups)		**d) Additional ingredients/amounts*** (Ex: 2 teaspoons Polycose, 1 Tablespoon MCT oil, 2 scoops Beneprotein) *If there are no additional ingredients/amount, record "N/A"
		b) Amount	**c) Unit**	
E4.		____ ____	Tsp……..1 Tbsp……..2 Oz……..3 cup ……..4	
E5.		____ ____	Tsp……..1 Tbsp……..2 Oz……..3 cup ……..4	

END MHs1

SECTION F: HEALTHCARE UTILIZATION

Now, I am going to ask you about all the places your child may have received care in the last year.

F1. During the past 12 months, where has (*name of child*) gone to receive medical care? **(Please circle "Yes" or "No" for EACH of the following places.)**

Did (name of child) go to…

		Yes	No
a.	A clinic or health care center	1	2
b.	A private doctor's office	1	2
c.	Hospital Outpatient Department	1	2
d.	The emergency room in a hospital	1	2 **(Skip to e)**
	1. How many times has (name of child) received care at the emergency room in the last year? ___ ___		
e.	Some other place	1	2 **(Skip to F2)**
	1. Please specify: _____		

Now I am going to ask you some questions about your child's use of health care. In this set of questions, I am going to use the words "health care provider" to mean any doctor, nurse practitioner, or physician's assistant you may go to for medical care.

F2. During the past 12 months, how many times did (*name of child*) see a health care provider, not including this CKID study visit or the visit at which you were screened for eligibility into the study? Include well child visits, sick visits and ER visits. **Do not include** times when (name of child) was hospitalized overnight.

___ ___ times

Don't Know..... -8

F3. During the past 12 months, when you or (*name of child*) went for medical care, did he/she usually (more than half of the time) see the same health care provider or group of providers for his/her medical appointments?

Yes 1

No 2

Don't Know..... -8

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The next questions ask about hospitalizations. Being hospitalized includes staying overnight or being admitted for a procedure that was done in one day. Please include all medical and psychiatric hospitalizations. This does not include being treated in the emergency room and then released the same day.

F4. During the past 12 months, has (*name of child*) been hospitalized (apart from when he or she was born)? Do not include overnight stays in the emergency room.

Yes ..... 1 **(Complete MAT)**

No ..... 2 **(Skip to F5)**

Don't Know ..... -8 **(Skip to F5)**

a. How many different times was (*name of child*) hospitalized during the past year?

___ ___ times

Don't Know ..... -8

Now, I am going to ask you some questions about care or social services that your child may have received in the last year.

F5. During the past 12 months, has (*name of child*) been seen by a social worker or a case manager to help him/her obtain services?

Yes 1

No 2

F6. During the past 12 months, has (*name of child*) received care or services from a psychologist, psychiatrist, psychiatric nurse, counselor, or other mental health professional?

Yes 1

No 2

F7. During the past 12 months, has an agency assisted (*name of child*) with food, such as food stamps or WIC, meals on wheels, food pantries, or arranged to have groceries delivered to the child's primary household (i.e., the home in which the child lives at least half the time)?

Yes 1

No 2

F8. During the past 12 months, has a social service agency helped you or (*name of child*) find a place to live?

Yes 1

No 2

F9. During the past 12 months, has (*name of child*) received care from a dentist or dental hygienist?

Yes 1
No 2

F10. During the past 12 months, has (*name of child*) seen a nutritionist or a dietician?

Yes 1
No 2

SECTION G: HEALTH INSURANCE

Now I am going to ask you questions about your child's health care coverage.

G1. Does (*name of child*) currently have any kind of health insurance or health care coverage? This includes both private and public insurance programs (e.g., Medicaid, SCHIP or MCHIP), dental insurance, and programs that help pay for medications.

Yes 1
No ..... 2 **(Skip to G14)**

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INSTRUCTIONS: ASK QUESTIONS G2 - G15. IF THE RESPONSE IS YES (CODE 1) ASK QUESTION "A" (FAR RIGHT COLUMN) UNLESS THE BOX IS SHADED.

Does (*name of child*) currently have...	YES	NO	NA	**A.** Do you or your family members pay for any of the insurance premium? YES	NO
G2. *CALIFORNIA ONLY: Medi-CAL?	1	2	**99**		
G3. *MARYLAND ONLY: Medical Assistance?	1	2	**99**		
G4. ALL STATES EXCEPT CALIFORNIA and MARYLAND: Medicaid?	1	2	**99**		
G5. Private Health Insurance plan from employer or workplace?	1	2 **(Skip to G6)**		1	2
G6. Private Health Insurance plan purchased directly?	1	2 **(Skip to G7)**		1	2
G7. Private Health Insurance plan through a state or local government program or community program?	1	2 **(Skip to G8)**		1	2
G8. CHIP (Children's Health Insurance Program)?	1	2 **(Skip to G9)**		1	2
G9. Military Health Care/VA?	1	2 **(Skip to G10)**		1	2
G10. CHAMPUS or other veteran's health insurance?	1	2 **(Skip to G11)**		1	2
G11. Student Health Coverage?	1	2 **(Skip to G12)**		1	2
G12. State-Sponsored Health Plan?	1	2 **(Skip to G13)**		1	2
G13. Dental Insurance?	1	2			
G14. Vision Insurance?	1	2			
G15. Other types of health insurance? Specify _____ _____ _____	1	2 **(Skip to G16)**			

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G16. Do any of these plans assist with prescriptions/medications?

Yes 1
No 2

TO BE COMPLETED BY CLINICAL SITE:

DATE: ___ ___/ ___ ___/ ___ ___ ___ ___
M M / D D / Y Y Y Y

INITIALS: ___ ___ ___

ADMINISTRATION:
(Circle "1", "2" or "3")

1 = Interviewer Assisted
2 = Self-Administered
3 = Both