Participant ID: _____ Participant Initials: _____

Clinical Center: _____ Site: _____ Visit Number: _____ Reset Patient / RC

CRF Date: ____ / ____ / ____ RC ID: _____ Reset All

MEDICAL HISTORY

PERSONAL MEDICAL HISTORY:

Within the last 5 years, were you diagnosed or treated by a doctor or other health professional:

1. For any cancer?
   - ☐1 Yes ⟶ ***Answer Questions a through l***
   - ☐0 No ⟶ ***Go to Question 2***
   - ☐88 Don't know ⟶ ***Go to Question 2***

a.	Was it for bladder cancer?	☐1 Yes	☐0 No	☐88 Don't know
b.	Was it for breast cancer?	☐1 Yes	☐0 No	☐88 Don't know
c.	Was it for colon or rectal cancer?	☐1 Yes	☐0 No	☐88 Don't know
d.	Was it for uterine cancer?	☐1 Yes	☐0 No	☐88 Don't know
e.	Was it for cancer of the head and neck?	☐1 Yes	☐0 No	☐88 Don't know
f.	Was it for blood cancer?	☐1 Yes	☐0 No	☐88 Don't know
g.	Was it for lung cancer?	☐1 Yes	☐0 No	☐88 Don't know
h.	Was it for cancer of the lymph nodes?	☐1 Yes	☐0 No	☐88 Don't know
i.	Was it for melanoma or skin cancer?	☐1 Yes	☐0 No	☐88 Don't know
j.	Was it for ovarian cancer?	☐1 Yes	☐0 No	☐88 Don't know
k.	Was it for prostate cancer?	☐1 Yes	☐0 No	☐88 Don't know
l.	Was it for any other type of cancer?	☐1 Yes	☐0 No	☐88 Don't know

1. Specify type of cancer: _____

Within the last 5 years, were you diagnosed or treated by a doctor or other health professional:

2.	For Asthma or Reactive Airway Disease?	☐1 Yes	☐0 No	☐88 Don't know
3.	For Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)?	☐1 Yes	☐0 No	☐88 Don't know
4.	For Hepatitis (B or C) infection?	☐1 Yes	☐0 No	☐88 Don't know
5.	For Lupus or Lupus Erythematosus	☐1 Yes	☐0 No	☐88 Don't know
6.	For Gout?	☐1 Yes	☐0 No	☐88 Don't know

MEDICAL HISTORY

For female participants only.
Male participants skip to Question #14 – RENAL HISTORY.

These next questions ask about your reproductive history and your general health as a woman.

7. How old were you when you had your first menstrual period?
___ ___ years old
❑88 Don't know

8. Have you ever been pregnant?
❑1 Yes ❑0 No

If ***NO***, skip to Question ***#12***.

9. How many live births have you had?
___ ___ live births

If ***"0"***, skip to Question ***#11***.

10. How old were you at your first live birth?
___ ___ years old
❑88 Don't know

11. Has a doctor or other health professional ever told you that you had pre-eclampsia during one or more of your pregnancies?
❑1 Yes ❑0 No ❑88 Don't know

12. Did you have a hysterectomy (removal of the uterus/womb with or without removal of the ovaries)?
❑1 Yes ❑0 No ❑88 Don't know

13. At what age did you complete your menopause (no menstrual period for 1 year)?
___ ___ years old
❑88 Don't know
❑99 I still have menstrual periods

RENAL HISTORY:

14. When were you first made aware of your kidney problem or protein in the urine?
❑1 During CRIC evaluation
❑2 Within the previous 6 months
❑3 6 months to under 1 year ago
❑4 1 year to under 3 years ago
❑5 3 years to under 5 years ago
❑6 5 years ago or longer
❑88 Don't know

15. Has a doctor or other health professional ever told you that your kidney disease was caused by diabetes?
❑1 Yes ❑0 No ❑88 Don't know

16. Has a doctor or other health professional ever told you that your kidney disease was caused by high blood pressure?
❑1 Yes ❑0 No ❑88 Don't know

17. Has a doctor or other health professional ever told you that your kidney disease was caused by glomerulonephritis?
❑1 Yes ❑0 No ❑88 Don't know

MEDICAL HISTORY

18. Has a doctor or other health professional ever told you that your kidney disease was caused by kidney stones or multiple kidney infections or kidney blockage? ❑1 Yes ❑0 No ❑88 Don't know

19. Has a doctor or other health professional ever told you that your kidney disease was caused by another condition? ❑1 Yes ❑0 No ❑88 Don't know

    a. If ***YES***, ***specify***: _____

20. Have you ever seen a nephrologist or a kidney doctor? ❑1 Yes ❑0 No ❑88 Don't know

    If ***NO*** or ***DON'T KNOW***, skip to Question ***#21.***

    a. If ***YES***, when did you first see a nephrologist or a kidney doctor about your kidney problem?
    - ❑1 During CRIC evaluation
    - ❑2 Within the previous 6 months
    - ❑3 6 months to under 1 year ago
    - ❑4 1 year to under 3 years ago
    - ❑5 3 years to under 5 years ago
    - ❑6 5 years ago or longer
    - ❑88 Don't know

    b. If ***YES***, when did you last see a nephrologist or a kidney doctor about your kidney problem?
    - ❑1 During CRIC evaluation
    - ❑2 Within the previous 6 months
    - ❑3 6 months to under 1 year ago
    - ❑4 1 year to under 3 years ago
    - ❑5 3 years to under 5 years ago
    - ❑6 5 years ago or longer
    - ❑88 Don't know

21. Have you ever seen any ***other*** doctor or health professional (e.g. internist, family practitioner, hypertension specialist) about your kidney problem? ❑1 Yes ❑0 No ❑88 Don't know

    If ***NO*** or ***DON'T KNOW***, skip to Question ***#22***

    a. If ***YES***, when did you first see the ***other*** doctor or health professional about your kidney problem?
    - ❑1 During CRIC evaluation
    - ❑2 Within the previous 6 months
    - ❑3 6 months to under 1 year ago
    - ❑4 1 year to under 3 years ago
    - ❑5 3 years to under 5 years ago
    - ❑6 5 years ago or longer
    - ❑88 Don't know

MEDICAL HISTORY

b. If ***YES***, when did you last see the ***other*** doctor or health professional about your kidney problem?

- ❑1 During CRIC evaluation
- ❑2 Within the previous 6 months
- ❑3 6 months to under 1 year ago
- ❑4 1 year to under 3 years ago
- ❑5 3 years to under 5 years ago
- ❑6 5 years ago or longer
- ❑88 Don't know

22. After seeing a nephrologist/kidney doctor or any another doctor / health professional(s) (e.g. internist, family practitioner, hypertension specialist) for your kidney problem, were any of the following things recommended, ordered, or prescribed:

a. Medical or laboratory procedures? ❑1 Yes ❑0 No ❑88 Don't know

1. If ***YES***, check all that apply:
   - ❑ Measure the level of protein in your urine
   - ❑ Measure your kidney function by a 24-hour urine test or iothalamate clearance test
   - ❑ Kidney ultrasound
   - ❑ Kidney biopsy
   - ❑ Other blood tests
   - ❑ Gave you one or more vaccines to prevent bacterial infections

b. Medications/prescriptions? ❑1 Yes ❑0 No ❑88 Don't know

1. If ***YES***, check all that apply:
   - ❑ Told to avoid anti-inflammatory drugs (e.g., NSAIDs) or other drugs that might harm your kidneys
   - ❑ Started or changed doses of drugs to lower your blood pressure
   - ❑ Started drugs to raise your blood counts (i.e., treat anemia)
   - ❑ Started or changed doses of drugs to treat your cholesterol levels
   - ❑ Started or changed doses of drugs to treat diabetes or high blood sugar
   - ❑ Started drugs to lower phosphate levels in your blood

c. Life style changes? ❑1 Yes ❑0 No ❑88 Don't know

1. If ***YES***, check all that apply:
   - ❑ Told to cut down on amount of protein you eat
   - ❑ Told to cut down on the amount of salt or sodium you eat
   - ❑ Told to cut down on the amount of potassium you eat
   - ❑ Referred you to a nutritionist or someone to review your diet
   - ❑ Told you to stop smoking tobacco
   - ❑ Told you to cut down on alcohol use

MEDICAL HISTORY

CARDIOVASCULAR HISTORY:

23. Have you ever been diagnosed with or has a doctor or other health professional ever told you that you have:

a.	Coronary artery disease (heart attack, angina)?	❑1 Yes	❑0 No	❑88 Don't know
b.	Prior revascularization of your heart blood vessels (e.g. balloon angioplasty, coronary stenting, coronary bypass surgery)?	❑1 Yes	❑0 No	❑88 Don't know
c.	Heart failure?	❑1 Yes	❑0 No	❑88 Don't know
d.	Atrial fibrillation or atrial flutter (an irregular heart rhythm)?	❑1 Yes	❑0 No	❑88 Don't know
e.	Stroke?	❑1 Yes	❑0 No	❑88 Don't know
f.	Peripheral vascular disease (claudication, amputation or procedure to open up blood vessels in arms or legs)?	❑1 Yes	❑0 No	❑88 Don't know

24. Do you have pain or cramping ***(not due to arthritis)*** in your calves or legs when walking that is relieved by resting? ❑1 Yes ❑0 No ❑88 Don't Know

25. Have you had a toe(s) or foot surgically amputated? ❑1 Yes ❑0 No ❑88 Don't Know

26. Have you had a leg surgically amputated? ❑1 Yes ❑0 No ❑88 Don't Know

27. Have you had a procedure to open blood vessels in your arms or legs (angioplasty, surgical vascular by-pass)? ❑1 Yes ❑0 No ❑88 Don't Know

Hypertension History:

28. Has a doctor or other health professional ever told you that you have hypertension or high blood pressure? ❑1 Yes ❑0 No

If ***NO***, skip to Question ***#29***.

a.	If ***YES***, how old were you when you were first told you had this condition?	___ ___ years old	❑88 Don't know
b.	Do you currently take prescribed medication for your hypertension or high blood pressure?	❑1 Yes ❑0 No	❑88 Don't know

MEDICAL HISTORY

High Cholesterol History:

29. Has a doctor or other health professional ever told you that your blood cholesterol level was high? ❑1 Yes ❑0 No ❑88 Don't know

If ***NO*** or ***DON'T KNOW,*** skip to Question ***#29b***.

a. If ***YES***, how old were you when you were first told you had this condition? ___ ___ years old ❑88 Don't know

b. Do you currently take prescribed medication for high blood cholesterol? ❑1 Yes ❑0 No ❑88 Don't know

DIABETIC HISTORY:

30. Has a doctor or other health professional ever told you ***(except during pregnancy)*** that you have diabetes or high blood sugar? ❑1 Yes ❑0 No ❑88 Don't Know

If ***NO*** or ***DON'T KNOW,*** skip to instructions before Question ***#35***.

a. How old were you when a doctor first told you that you had diabetes? ___ ___ years old ❑88 Don't know

b. Are you on a weight loss or exercise program to control your blood sugar? ❑1 Yes ❑0 No ❑88 Don't Know

c. Are you currently taking insulin? ❑1 Yes ❑0 No ❑88 Don't Know

d. Are you currently taking injectable drugs, other than insulin, to manage your blood sugar? ❑1 Yes ❑0 No ❑88 Don't Know

e. Do you currently take diabetes pills to lower your blood sugar? (These are sometimes called oral agents or oral hypoglycemic agents.) ❑1 Yes ❑0 No ❑88 Don't Know

f. How many of the last 7 days did you test your blood sugar?

❑1 1 day ❑5 5 days
❑2 2 days ❑6 6 days
❑3 3 days ❑7 7 days
❑4 4 days ❑99 None

MEDICAL HISTORY

g. Of the days that you check your blood sugar, how many times a day do you usually test it? (check one response only)

☐1 Once a day ☐3 3 times a day ☐5 5 times a day ☐99 I do not test my blood sugar
☐2 Twice a day ☐4 4 times a day ☐6 6 times a day or more

h. How old were you when you started taking diabetes medications? ___ ___ years old ☐88 Don't know

31. When was the last time you had your eyes examined by a doctor? (***If known, write number and check either days, weeks, months or years***)

_____ ☐1 Days ago
☐2 Weeks ago
☐3 Months ago
☐4 Years ago
☐0 Never
☐88 Don't Know

32. Has a doctor ever told you that diabetes has affected your eyes or that you have retinopathy? ☐1 Yes ☐0 No ☐88 Don't Know

33. Has a doctor ever told you that you have diabetic neuropathy? (Diabetic neuropathy is when diabetes has affected the nerves of your hands or feet or any other parts of your body.) ☐1 Yes ☐0 No ☐88 Don't Know

34. Do you have or have you had any of these problems:

a. Numbness or tingling or loss of sensation in your hands or feet (other than falling asleep because you laid on your arm or leg)? ☐1 Yes ☐0 No ☐88 Don't Know

b. Decreased ability to feel the hotness or coldness of things you touch? ☐1 Yes ☐0 No ☐88 Don't Know

c. Sores or ulcers on your feet or ankles? ☐1 Yes ☐0 No ☐88 Don't Know

If you do not have hypertension/high blood pressure, high blood cholesterol, diabetes, skip to Question #36.

35. Are you currently doing any of the following:

a. Controlling or trying to lose weight? ☐1 Yes ☐0 No

b. Exercising? ☐1 Yes ☐0 No

c. Cutting back on alcohol use? ☐1 Yes ☐0 No ☐99 I don't drink

d. Quitting smoking? ☐1 Yes ☐0 No ☐99 I don't smoke

e. Reducing tension/stress? ☐1 Yes ☐0 No

MEDICAL HISTORY

f. Using less salt or sodium in your diet? ❑1 Yes ❑0 No

g. Eating a low fat diet? ❑1 Yes ❑0 No

h. Reducing your protein intake? ❑1 Yes ❑0 No

i. Reducing your potassium intake? ❑1 Yes ❑0 No

j. Reducing your phosphate intake? ❑1 Yes ❑0 No

k. Making other diet changes? ❑1 Yes ❑0 No

l. Doing anything else? ❑1 Yes ❑0 No

SOCIAL HISTORY:

Tobacco and Smoking History:

36. Have you ever used chewing tobacco, snuff, or other smokeless tobacco products? ❑1 Yes ❑0 No

Cigarettes:

37. Have you ever smoked any cigarettes?
    - ❑1 Yes → ***Go to Question 38***
    - ❑0 No → ***Go to Question 43***

38. Have you smoked more than 100 cigarettes (approximately 5 packs) in your lifetime? ❑1 Yes ❑0 No

39. How old were you when you first started smoking cigarettes regularly ***(3 or more times a week)***?
    ___ ___ years old
    ❑0 Never smoked regularly
    ❑88 Don't Know

40. Do you currently smoke cigarettes? ❑1 Yes ❑0 No

    a. If ***NO***, at what age did you quit smoking cigarettes? ___ ___ years old ❑88 Don't Know

41. How many cigarettes do you or did you usually smoke per day? ___ ___ ___ cigs/day ❑0 Less than 1 per day

42. How long have you smoked this amount? ***(Write number of months or years)***
    ___ ___ ❑1 months ❑2 years
    ❑88 Don't Know

MEDICAL HISTORY

Cigars:

43. Have you ever smoked cigars?
    - ☐1 Yes ⟶ ***Go to Question 44***
    - ☐0 No ⟶ ***Go to Question 47***

44. Have you smoked at least 20 cigars in your lifetime? ☐1 Yes ☐0 No

45. Do you currently smoke cigars? ☐1 Yes ☐0 No

46. How many cigars do you or did you usually smoke per day? ___ ___ cigars ☐0 Less than 1 per day

Alcohol Use History:

For Questions 47 through 49, an alcoholic drink can be:

 12 ounce can of beer **OR**  5 ounce glass of wine **OR**  1 shot of liquor

47. During the past 12 months, how often have you had an alcoholic drink? Choose only one response
    - ☐10 Every day
    - ☐9 5 to 6 times a week
    - ☐8 3 to 4 times a week
    - ☐7 2 times a week
    - ☐6 1 time a week
    - ☐5 2 to 3 times a month
    - ☐4 1 time a month
    - ☐3 3 to 11 times
    - ☐2 1 or 2 times
    - ☐1 None ***Go to Question 50***

48. During the last 12 months, what is the largest number of alcoholic drinks that you had in a 24-hour period?
    - ☐10 36 or more drinks
    - ☐9 24 to 35 drinks
    - ☐8 18 to 23 drinks
    - ☐7 12 to 17 drinks
    - ☐6 8 to 11 drinks
    - ☐5 5 to 7 drinks
    - ☐4 4 drinks
    - ☐3 3 drinks
    - ☐2 2 drinks
    - ☐1 1 drink
    - ☐98 Don't wish to answer

MEDICAL HISTORY

 12 ounce can of beer **OR**  5 ounce glass of wine **OR**  1 shot of liquor

49. During the last 12 months,

a. **For men**, how often did you have 5 or more alcoholic drinks within a two-hour period? Choose only one response

- ☐ 9 Every day
- ☐ 8 5 to 6 days a week
- ☐ 7 3 to 4 days a week
- ☐ 6 2 days a week
- ☐ 5 1 day a week
- ☐ 4 2 or 3 days a month
- ☐ 3 1 day a month
- ☐ 2 3 to 11 days
- ☐ 1 1 or 2 days
- ☐ 98 Don't wish to answer
- ☐ 99 None

b. **For women**, how often did you have 4 or more alcoholic drinks within a two-hour period? Choose only one response.

- ☐ 9 Every day
- ☐ 8 5 to 6 days a week
- ☐ 7 3 to 4 days a week
- ☐ 6 2 days a week
- ☐ 5 1 day a week
- ☐ 4 2 or 3 days a month
- ☐ 3 1 day a month
- ☐ 2 3 to 11 days
- ☐ 1 1 or 2 days
- ☐ 98 Don't wish to answer
- ☐ 99 None

Recreational Drug Use History:

50. Have you ever used:		**If *YES*, how many times in your lifetime have you used……?**	**Have you used within the past 30 days?**
a. Marijuana?	❑ 1 Yes ❑ 0 No ❑ 88 Don't Know	❑ 1 1 to 2 times ❑ 2 3 to 10 times ❑ 3 11 to 99 times ❑ 4 100 times or more	❑ 1 Yes ❑ 0 No ❑ 88 Don't Know
b. Methamphetamines?	❑ 1 Yes ❑ 0 No ❑ 88 Don't Know	❑ 1 1 to 2 times ❑ 2 3 to 10 times ❑ 3 11 to 99 times ❑ 4 100 times or more	❑ 1 Yes ❑ 0 No ❑ 88 Don't Know
c. Cocaine (snorted, smoked/inhaled)?	❑ 1 Yes ❑ 0 No ❑ 88 Don't Know	❑ 1 1 to 2 times ❑ 2 3 to 10 times ❑ 3 11 to 99 times ❑ 4 100 times or more	❑ 1 Yes ❑ 0 No ❑ 88 Don't Know

MEDICAL HISTORY

50. Have you ever used:		If *YES*, how many times in your lifetime have you used……?	Have you used within the past 30 days?
d. Injected cocaine?	❑1 Yes ❑0 No ❑88 Don't Know	❑1 1 to 2 times ❑2 3 to 10 times ❑3 11 to 99 times ❑4 100 times or more	❑1 Yes ❑0 No ❑88 Don't Know
e. Injected heroin?	❑1 Yes ❑0 No ❑88 Don't Know	❑1 1 to 2 times ❑2 3 to 10 times ❑3 11 to 99 times ❑4 100 times or more	❑1 Yes ❑0 No ❑88 Don't Know
f. Other injected street drugs? If ***YES***, ***specify***: _____	❑1 Yes ❑0 No ❑88 Don't Know	❑1 1 to 2 times ❑2 3 to 10 times ❑3 11 to 99 times ❑4 100 times or more	❑1 Yes ❑0 No ❑88 Don't Know

HEALTH INSURANCE:

51. Do you currently have health insurance? ❑1 Yes ❑0 No

52. What kind of health insurance coverage do you have?
(check all that apply)
- ❑1 Medicare benefits
- ❑1 Medicaid benefits
- ❑1 Group Health Plan provided by an employer (for example: HMO, PPO, POS)
- ❑1 Veterans Affairs (VA) benefits
- ❑1 CHAMPUS or other military benefits
- ❑1 Other Specify: _____

53. Was there ever a time when you were not covered by health insurance? ❑1 Yes ❑0 No

a. If "Yes", were you not covered by health insurance one month or more? ❑1 Yes ❑0 No

b. If "Yes", how long has it been since the last time that you were not covered by health insurance?
- ❑1 Less than 3 years ago
- ❑2 Between 3 and 10 years ago
- ❑3 More than 10 years ago

54. Were you ever denied health insurance? ❑1 Yes ❑0 No

55. Were you ever unable to fill a prescription because of the cost? ❑1 Yes ❑0 No

56. Were you ever unable to see your doctor because of the cost? ❑1 Yes ❑0 No

MEDICAL HISTORY

FAMILY HISTORY:

57. How many half or full brothers and sisters do/did you have? ***(include those who died)*** ___ ___

Has a health care provider ever diagnosed ***your mother or father*** or ***your siblings or children*** with any of the following conditions?

[Check for ***all*** medical conditions that apply. If you don't have siblings or children, check ***"N/A"*** in the appropriate column.]

Condition	Mother	Father	Any siblings (Brothers and Sisters)	Any children
58. Heart attack, coronary artery bypass surgery, or balloon angioplasty (PTCA)?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
59. Stroke?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
60. Heart failure?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
61. High cholesterol?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
62. High blood pressure?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
63. Diabetes or high blood sugar?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A

MEDICAL HISTORY

Condition	Mother	Father	Any siblings (Brothers and Sisters)	Any children
64. Peripheral vascular disease (poor circulation in toes, feet and legs)?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
65. Treated for kidney failure with dialysis?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A
66. Treated for kidney failure with kidney transplantation?	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A	❑1 Yes ❑0 No ❑88 Don't know ❑99 N/A

For Research Coordinator use only: CRF was: ❑1 Self-administered ❑2 Interviewer-administered