



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| b. Was it for breast cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| c. Was it for colon or rectal cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| d. Was it for uterine cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| e. Was it for cancer of the head and neck? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| f. Was it for blood cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| g. Was it for lung cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| h. Was it for cancer of the lymph nodes? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| i. Was it for melanoma or skin cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| j. Was it for ovarian cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| k. Was it for prostate cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| l. Was it for any other type of cancer? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> 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? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| 3. For Chronic Obstructive Pulmonary Disease (emphysema or chronic bronchitis)? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| 4. For Hepatitis (B or C) infection? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| 5. For Lupus or Lupus Erythematosus | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |
| 6. For Gout? | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₈₈ Don't know |



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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



Participant ID:

Participant Initials:

Clinical Center:

Site:

Visit Number:

CRF Date:

RC ID:

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 #23.

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



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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

If there is a "Yes" response to either Question #20 or Question #21, please complete Question #22. If there is a "No" or "Don't Know" response to both Question #20 and Question #21, please skip to Question #23.

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



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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



Participant ID:

Participant Initials:

Clinical Center:

Site:

Visit Number:

CRF Date:

RC ID:

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



Participant ID:

Participant Initials:

Clinical Center:

Site:

Visit Number:

CRF Date:

RC ID:

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

₅ 2 to 3 times a month

₉ 5 to 6 times a week

₄ 1 time a month

₈ 3 to 4 times a week

₃ 3 to 11 times

₇ 2 times a week

₂ 1 or 2 times

₆ 1 time a week

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

₄ 4 drinks

₉ 24 to 35 drinks

₃ 3 drinks

₈ 18 to 23 drinks

₂ 2 drinks

₇ 12 to 17 drinks

₁ 1 drink

₆ 8 to 11 drinks

₉₈ Don't wish to answer

₅ 5 to 7 drinks



Participant ID:

Participant Initials:

Clinical Center:

Site:

Visit Number:

CRF Date:

RC ID:

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?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know	<input type="checkbox"/> ₁ 1 to 2 times <input type="checkbox"/> ₂ 3 to 10 times <input type="checkbox"/> ₃ 11 to 99 times <input type="checkbox"/> ₄ 100 times or more	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know
b. Methamphetamines?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know	<input type="checkbox"/> ₁ 1 to 2 times <input type="checkbox"/> ₂ 3 to 10 times <input type="checkbox"/> ₃ 11 to 99 times <input type="checkbox"/> ₄ 100 times or more	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know
c. Cocaine (snorted, smoked/inhaled)?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know	<input type="checkbox"/> ₁ 1 to 2 times <input type="checkbox"/> ₂ 3 to 10 times <input type="checkbox"/> ₃ 11 to 99 times <input type="checkbox"/> ₄ 100 times or more	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know



Participant ID: _____

Participant Initials: _____

Clinical Center: _____

Site: _____

Visit Number: _____

CRF Date: _____

RC ID: _____

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?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know	<input type="checkbox"/> ₁ 1 to 2 times <input type="checkbox"/> ₂ 3 to 10 times <input type="checkbox"/> ₃ 11 to 99 times <input type="checkbox"/> ₄ 100 times or more	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know
e. Injected heroin?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know	<input type="checkbox"/> ₁ 1 to 2 times <input type="checkbox"/> ₂ 3 to 10 times <input type="checkbox"/> ₃ 11 to 99 times <input type="checkbox"/> ₄ 100 times or more	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know
f. Other injected street drugs? If YES, specify: _____	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₈₈ Don't Know	<input type="checkbox"/> ₁ 1 to 2 times <input type="checkbox"/> ₂ 3 to 10 times <input type="checkbox"/> ₃ 11 to 99 times <input type="checkbox"/> ₄ 100 times or more	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> 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



Participant ID:

Participant Initials:

Clinical Center:

Site:

Visit Number:

CRF Date:

RC ID:

MEDICAL HISTORY

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

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