

Participant ID:

Participant Initials:

Clinical Center:

Site:

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CRF Date:

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MEDICAL HISTORY

PERSONAL MEDICAL HISTORY:

1. Has a doctor or other health professional ever told you that you have any of the conditions listed below?

a. Diagnosed or treated for any cancer within the last 5 years? ₁ Yes ₀ No ₈₈ Don't know

If **YES**, was it:

- Cancer of the bladder? ₁ Yes ₀ No
- Breast cancer? ₁ Yes ₀ No
- Colon or rectal cancer? ₁ Yes ₀ No
- Cancer of the uterus? ₁ Yes ₀ No
- Cancer of the head and neck? ₁ Yes ₀ No
- Blood cancer? ₁ Yes ₀ No
- Lung cancer? ₁ Yes ₀ No
- Cancer of the lymph nodes? ₁ Yes ₀ No
- Melanoma or skin cancer? ₁ Yes ₀ No
- Cancer of the ovaries? ₁ Yes ₀ No
- Prostate cancer? ₁ Yes ₀ No
- Any other type of cancer? ₁ Yes ₀ No

If **YES**, *specify*: _____

- b. Asthma or reactive airway disease? ₁ Yes ₀ No ₈₈ Don't know
- c. Chronic Obstructive Pulmonary Disease (emphysema)? ₁ Yes ₀ No ₈₈ Don't know
- d. Hepatitis (B or C) infection? ₁ Yes ₀ No ₈₈ Don't know
- e. Rheumatoid Arthritis? ₁ Yes ₀ No ₈₈ Don't know
- f. Gout? ₁ Yes ₀ No ₈₈ Don't know

For female participants only.

Male participants skip to Question #12 – RENAL HISTORY.

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

2. How old were you when you had your first menstrual period? _____ years old
₈₈ Don't know

3. What was the date of your last menstrual period?
____/____/____
MM DD YYYY
₈₈ Don't know

4. Have you ever been pregnant? ₁ Yes ₀ No

If **NO**, skip to Question #8.

5. How many live births have you had? _____ live births

If **"0"**, skip to Question #7.

6. How old were you at your first live birth? _____ years old
₈₈ Don't know



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7. 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
8. Have you had surgery to remove your ovaries? ₁ Yes ₀ No
- a. If **YES**, how many ovaries were removed? ₁ One ₂ Both ₈₈ Don't know
9. 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
10. Do you take or did you ever take estrogen either as pill, injection or patch? (*Do not include creams or birth control containing estrogen*) ₁ Yes ₀ No ₈₈ Don't know
- a. If **YES**, how many years have you taken estrogen? _____ years
₈₈ Don't know
11. Do you or did you ever take progestin with estrogen? (*Do not include creams*) ₁ Yes ₀ No ₈₈ Don't know
- a. If **YES**, how many years have you taken progestin with estrogen? _____ years
₈₈ Don't know

RENAL HISTORY:

12. 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
13. 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
14. 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
15. 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
- If **YES** to glomerulonephritis, **check one:**
- i. IgA nephropathy: ₁ Yes ₀ No ₈₈ Don't know
- ii. Lupus nephritis: ₁ Yes ₀ No ₈₈ Don't know
- iii. Other: ₁ Yes ₀ No ₈₈ Don't know



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MEDICAL HISTORY

16. 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

17. 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

If **YES**, specify: _____

18. Have you ever had:

a. A kidney arteriogram/X-ray of your kidney with contrast dye?

₁ Yes ₀ No ₈₈ Don't know

If **YES**, when?

____ / ____ ₈₈ Don't know
MM YYYY

b. A kidney biopsy (removal of a small piece of the kidney)?

₁ Yes ₀ No ₈₈ Don't know

If **YES**, when?

____ / ____ ₈₈ Don't know
MM YYYY

c. A kidney ultrasound (pictures of the kidney taken with sound waves)?

₁ Yes ₀ No ₈₈ Don't know

If **YES**, when?

____ / ____ ₈₈ Don't know
MM YYYY

For Research Coordinator use only:

If YES is checked for Question # s 18 a, b, and/or c, complete EVENT CRF.

19. 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 #20.

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



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c. After seeing a nephrologist or a kidney doctor for your kidney problem, were any of the following things recommended, ordered, or prescribed:

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

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

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

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

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

If **YES**, check all that apply:

- Told to cut down on the 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

20. Have you ever seen any **other** doctor or health professional about your kidney problem? 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 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



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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

c. After seeing **another** doctor or health professional for your kidney problem, were any of the following things recommended, ordered, or prescribed:

i. Medical or laboratory procedures?

- ₁ Yes ₀ No ₈₈ Don't know

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

ii. Medications/prescriptions?

- ₁ Yes ₀ No ₈₈ Don't know

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

iii. Life style changes?

- ₁ Yes ₀ No ₈₈ Don't know

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



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MEDICAL HISTORY

CARDIOVASCULAR HISTORY:

21. 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
22. Do you have pain or cramping in your calves or legs when walking (**not due to arthritis**) that is relieved by resting? ₁ Yes ₀ No ₈₈ Don't Know
23. Have you had a toe(s) or foot surgically amputated due to infection or poor circulation? ₁ Yes ₀ No ₈₈ Don't Know
24. Have you had a leg surgically amputated due to infection or poor circulation? ₁ Yes ₀ No ₈₈ Don't Know
25. 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:

26. How long has it been since you last had your blood pressure taken by a doctor or other health professional?
- ₀ Never
 - ₁ Within the previous 6 months
 - ₂ 6 months to under 1 year ago
 - ₃ 1 year to under 3 years ago
 - ₄ 3 years to under 5 years ago
 - ₅ 5 years ago or longer
 - ₈₈ Don't know

If **NEVER**, skip to Question #28.

27. 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 #28.

- 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



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MEDICAL HISTORY

High Cholesterol History:

28. How long has it been since you had your blood cholesterol measured by a doctor or other health professional?

- ₀ Never
- ₁ Within the previous 6 months
- ₂ 6 months to under 1 year ago
- ₃ 1 year to under 3 years ago
- ₄ 3 years to under 5 years ago
- ₅ 5 years ago or longer
- ₈₈ Don't know

If **NEVER**, skip to Question #30 – **DIABETIC 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 your 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

d. 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

e. How old were you when you started taking diabetes medications?

- ___ ___ years old ₈₈ Don't know



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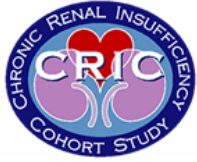
MEDICAL HISTORY

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, that is, 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 had) any of these problems that may be related to your diabetes?
- a. Numbness or tingling 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. Loss of sensation in your hands or feet? ₁ Yes ₀ No ₈₈ Don't Know
- c. Decreased ability to feel the hotness or coldness of things you touch? ₁ Yes ₀ No ₈₈ Don't Know
- d. 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. Because of your hypertension/high blood pressure, high blood cholesterol and/or diabetes, are you currently:
- a. Controlling or trying to lose weight? ₁ Yes ₀ No
- b. Exercising? ₁ Yes ₀ No
- c. Restricting alcohol use? ₁ Yes ₀ No
- d. Quitting smoking? ₁ Yes ₀ No
- e. Reducing tension/stress? ₁ Yes ₀ No
- f. Using less salt or sodium in your diet? ₁ Yes ₀ No
- g. Consuming low fat diet? ₁ Yes ₀ No
- h. Making other diet changes? ₁ Yes ₀ No
- i. Doing anything else? ₁ Yes ₀ No

Specify: _____



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MEDICAL HISTORY

SOCIAL HISTORY:

Smoking History:

36. Have you smoked at least 100 cigarettes during your entire life? ₁ Yes ₀ No
(approximately 5 packs)

If **NO**, skip to Question #41.

37. 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

38. Do you smoke cigarettes now? ₁ Yes ₀ No
a. If **NO**, at what age did you quit smoking cigarettes? _____ years old ₈₈ Don't Know

If you DO NOT smoke cigarettes now, skip to Question #41.

39. How many cigarettes do you smoke per day? (*If known, write number and check either cigarettes/day or packs/day*) _____ ₁ cigs/day
₂ packs/day
₁ Less than 1 per day
₂ Varies

40. How long have you smoked this amount? (*If known, write number and check either months or years*) _____ ₁ months ₂ years

41. Have you ever smoked at least 20 cigars in your entire life? ₁ Yes ₀ No
If **NO**, skip to Question #44 – **Alcohol Use History**.

42. Do you currently smoke cigars? ₁ Yes ₀ No
If **NO**, skip to Question #44 – **Alcohol Use History**.

43. How many cigars do you smoke per day? _____ cigars



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MEDICAL HISTORY

Alcohol Use History:

44. During the past 12 months, how often have you had a drink of any kind of alcoholic beverage?

- ₈ Every day or almost every day
- ₇ 5 - 6 times a week
- ₆ 3 - 4 times a week
- ₅ 1 - 2 times a week
- ₄ 2 - 4 times a month
- ₃ Once a month
- ₂ Less than once a month but at least once in the past 12 months
- ₁ Not at all in the past 12 months (**Skip to Question #46 – Recreational Drug Use History.**)
- ₀ Never had any beverage containing alcohol (**Skip to Question #46 – Recreational Drug Use History.**)

a. If you had a drink in the past 12 months, on an average how many drinks did you consume? (**1 drink = a 12-oz can of beer, 4 oz. of wine or a 1 oz. shot of hard liquor**) _____ drinks

45. What is the largest number of drinks containing alcohol that you had in any single day during the last 12 months?

- ₅ 12 to 23 drinks
- ₄ At least 8, but less than 12 drinks
- ₃ 5 to 7 drinks
- ₂ 3 to 4 drinks
- ₁ 1 to 2 drinks
- ₉₈ Don't wish to answer (**Skip to Question #46**)

a. Based on the largest number of drinks on any single day as responded in **Question #45** in the last 12 months how often did you have that many drinks?

- ₈ Every day or nearly every day
- ₇ 3 to 4 times a week
- ₆ Once or twice a week
- ₅ 1 to 3 times a month
- ₄ 7 to 11 times in the past year
- ₃ 3 to 6 times in the past year
- ₂ Twice in the past year
- ₁ Once in the past year



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Recreational Drug Use History:

46. 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
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



Participant ID: _____

Participant Initials: _____

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MEDICAL HISTORY

Condition	Mother	Father	Any siblings (Brothers and Sisters)	Any children
53. Diabetes or high blood sugar?	<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
54. 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
55. 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
a. If YES , at what age were they <u>first</u> treated?	_____ (age) <input type="checkbox"/> ₈₈ Don't know	_____ (age) <input type="checkbox"/> ₈₈ Don't know	_____ (age) <input type="checkbox"/> ₈₈ Don't know	_____ (age) <input type="checkbox"/> ₈₈ Don't know
56. 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
a. If YES , at what age were they <u>first</u> treated?	_____ (age) <input type="checkbox"/> ₈₈ Don't know	_____ (age) <input type="checkbox"/> ₈₈ Don't know	_____ (age) <input type="checkbox"/> ₈₈ Don't know	_____ (age) <input type="checkbox"/> ₈₈ Don't know

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