FORM 1: PARENTS AND SIBLINGS OF EDIC/DCCT PATIENT

A. IDENTIFYING INFORMATION

1. Clinic Number: _____ _____
2. Patient ID Number: _____ _____ _____ _____ _____
3. Patient's Initials: _____ _____ _____
4. Form date: _____ _____ _____ (mo day yr)

(FOLD HERE)

(If more than 6 siblings, use extra copies of Page 1. Code 7th sibling as S7, etc. Complete ID information on all pages).

If patient is adopted, disregard Page 1 of this form, but indicate that the patient is adopted, and use Page 2 as appropriate. Please provide information for members of the immediate family of the DCCT/EDIC patient, listing the patient as a "child" below. Supply information in "If Diabetic" columns only if patient is diabetic.

NAME	CODE	SEX	SAME BIOLO-GICAL PARENTS? No(1) Yes (2)	DATE OF BIRTH Mo/Day/Yr	LIVING? No (1) Yes (2)	CURRENT AGE OR AGE AT DEATH Years	DIABETIC? No(1) Yes(2)	IF DIABETIC: AGE DIABETES DIAG-NOSED?	IF DIABETIC: USE INSULIN? No (1) Yes (2)	IF DIABETIC: RETINO-PATHY? No (1) Yes (2)	IF DIABETIC: NEPHRO-PATHY? No (1) Yes (2)	RELIABLE PHONE # (W/AREA CODE) INDICATE DAY(D) OR EVENING (E)
FATHER:	FA	M										
MOTHER:	MO	F										
DCCT/EDIC PATIENT	PT											
OLDESR SIBLING:	S1											
NEXT SIBLING	S2											
NEXT SIBLING	S3											
NEXT SIBLING	S4											
NEXT SIBLING	S5											
NEXT SIBLING	S6											

Does the DCCT/EDIC patient have diabetic offspring? (Y) (N) If yes, please complete Form 2 showing the DCCT/EDIC patient as father or mother.

Name of person completing this form: _____

Certification No. (If completed by e-mail, disregard) ____ ____-____ ____

(FOLD HERE)

FORM 2: SPOUSE/OFFSPRING OF DCCT/EDIC PT (DO NOT USE IF NO AFFECTED CHILDREN)

A. IDENTIFYING INFORMATION

1. Clinic Number: _____ _____

2. Patient ID Number: _____ _____ _____ _____ _____

3. Patient's Initials: _____ _____ _____

(FOLD HERE)

4. Form date: _____ _____ _____
mo day yr

(If more than 8 children, use extra copies of Page 1. Code 9th child as C9, etc. Complete ID information on on all pages).

Please provide information for spouse and offspring of the DCCT/EDIC patient, listing the patient as a parent. If diabetic offspring was from previous marriage, provide information on biological parent (i.e., former spouse) and list other children of that marriage. For father or mother, as appropriate, indicate PT (patient) and WI (wife) or HU (husband) for other patient under CODE column. Supply information in "If Diabetic" columns only if family member is diabetic.

NAME	CODE	SEX	SAME BIOLO-GICAL PARENTS? No(1) Yes (2)	DATE OF BIRTH Mo/Day/Yr	LIVING? No (1) Yes (2)	CURRENT AGE OR AGE AT DEATH Years	DIABETIC? No(1) Yes(2)	IF DIABETIC: AGE DIABETES DIAG-NOSED?	IF DIABETIC: USE INSULIN? No (1) Yes (2)	IF DIABETIC: RETINO-PATHY? No (1) Yes (2)	IF DIABETIC: NEPHRO-PATHY? No (1) Yes (2)	RELIABLE PHONE # (W/AREA CODE) INDICATE DAY(D) OR EVENING (E)
FATHER:		M										
MOTHER:		F										
OLDEST CHILD:	C1											
NEXT CHILD:	C2											
NEXT CHILD:	C3											
NEXT CHILD:	C4											
NEXT CHILD:	C5											
NEXT CHILD:	C6											
NEXT CHILD:	C7											
NEXT CHILD:	C8											

Name of person completing this form:

Certification No. (If completed by e-mail, disregard)

(FOLD HERE) _____ ___ ___-___ ___

FORM 3: AFFECTED RELATIVES (FOR CLINIC USE ONLY – DO NOT SEND TO DCC)

A. IDENTIFYING INFORMATION

1. Clinic Number: _____ _____
2. Patient ID Number: _____ _____
3. Patient's Initials: _____ _____ _____
4. Form date: _____ _____ _____
   mo day yr

List names and addresses for any 1st degree relatives (parent, sibling or offspring) identified as diabetic on pages 1 or 2 of this form.

NAME	ADDRESS