

FIND Medical Questionnaire

Barcode and Participant ID

Study Coordinator ID _____

Date of interview (MM/DD/YYYY) ____ | ____ | _____

The informant is:

Participant Proxy

If **Proxy**, give name and relationship to the participant: _____

Enrolled In (Select All that Apply)

Family Study AA MALD Diabetic AA MALD Non-Diabetic MA MALD
 Hypernormal Control

If Female, are you pregnant?

No Yes Don't Know

If **No**, complete the entire form.

If **Yes**, record the estimated date of delivery (MM/DD/YYYY): ____ / ____ / _____, collect the data in Section A only, and complete the interview and sample collection when the participant is at least six weeks post partum.

If **Don't Know**, perform a urine pregnancy test. If the test is negative, complete the entire form. If the test is positive collect the data in Section A only and complete the interview and sample collection when the participant is at least six weeks post partum.

A. PARTICIPANT INFORMATION

1. **Name:** _____
Last First Middle Maiden

2. **Address:** _____
Street or Descriptive Address (for those without a street address) Apt City

State/Province Postal code Country

3. **Telephone:** Home ____ - ____ - ____ Work ____ - ____ - ____
or if outside the U.S.:
Country code ____ Home ____ Work ____

4. **Cell phone:** ____ - ____ - ____

5. **Pager:** ____ - ____ - ____

6. **Fax:** ____ - ____ - ____

7. **E-mail:** _____

8. **Birth date (MM/DD/YYYY):** ____ | ____ | _____

9. **Social Security Number:** ____ - ____ - ____

Barcode and
Participant ID

10. **Sex:** Male Female

11. **Ethnicity:** African American American Indian; tribal identifier ____
European American Mexican American Other Hispanic Other _____

12. **Country of birth:** _____ **City of Birth:** _____

13. **Name of your primary doctor:**

Telephone: _____ - _____ - _____ **OR** if outside the U.S.
Country code _____ Tel _____

Location: _____
Street *Suite* *City*

State/Province *Postal code* *Country*

14. **Name of your dialysis or transplant unit:**

Telephone: _____ - _____ - _____ **OR** if outside the U.S.
Country code _____ Tel _____

Location: _____
Street *Suite* *City*

State/Province *Postal code* *Country*

15. **Name of your nephrologist:**

Telephone: _____ - _____ - _____ **OR** if outside the U.S.
Country code _____ Tel _____

Location: _____
Street *Suite* *City*

State/Province *Postal code* *Country*

16. **Name of your eye doctor:**

Telephone: _____ - _____ - _____ **OR** if outside the U.S.
Country code _____ Tel _____

Location: _____
Street *Suite* *City*

State/Province *Postal code* *Country*

Barcode and
Participant ID

17. Are you currently participating in another study?

No Yes

If yes, please specify: _____

B. HEIGHT AND WEIGHT

18. Current height and weight: (ft) __ (in) __ __ (cm) __ __ __ (weight lbs) __ __ __ (kilos) __ __ __

19. Maximum weight or dry weight (lbs.): __ __ __ (kilos) __ __ __

20. Age and height at maximum weight: (years) __ __ (ft) __ (in) __ __ (cm) __ __ __

21. Have you ever had a major leg amputation (*above the ankle*)?

No Yes

If **Yes**, specify locations (*Mark all that apply*): Left below the knee Right below the knee
Left above the knee Right above the knee

C. KIDNEY DISEASE

22. Do you have high blood pressure?

No Yes Don't know

If **Yes**, when was your high blood pressure diagnosed (year)? _____

23. Have you ever had a kidney biopsy?

No Yes Don't know

If **Yes**, when did you have the kidney biopsy (year)? _____

Where was the kidney biopsy performed? _____

24. Do you have kidney failure requiring dialysis or transplant?

No Yes

If **Yes**, indicate the date of onset of dialysis treatment (MM/DD/YYYY): __ __ | __ __ | __ __ __ __

If **No**, skip to section D.

25. Have you ever had an organ transplant?

No Yes Please Specify _____

26. What caused your kidney failure/renal insufficiency (*Mark all that apply*)?

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polycystic kidney disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lupus nephritis |
| <input type="checkbox"/> IgA nephropathy | <input type="checkbox"/> Kidney cancer |
| <input type="checkbox"/> Membranous glomerulonephritis | <input type="checkbox"/> Obstruction |
| <input type="checkbox"/> Focal glomerulosclerosis | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

D. HISTORY OF DIABETES

27. Has a doctor or other health care provider told you that you had diabetes?

No Yes Don't know

If **Yes**, at what age were you diagnosed? __ __ **OR** in what year were you diagnosed? __ __ __ __

Barcode and Participant ID	
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28. **Have you ever been treated for diabetic ketoacidosis or coma?**

- No Yes Don't know

29. **Have you ever taken insulin shots to treat your diabetes?**

- No Yes Don't know

If **Yes**, how soon after diagnosis did you first begin taking insulin?

- Within 1 year At least 1 year after diagnosis

Once you started taking insulin shots, did you ever go at least one month without insulin treatment?

- No Yes Don't know

E. DIABETIC EYE DISEASE

30. **Have you ever had laser treatment of your retina(s) done for diabetes?**

- No Yes Don't know

31. **Have you ever been treated for bleeding inside your eye that was not due to trauma?**

- No Yes Don't know

32. **Have you ever seen an ophthalmologist or optometrist (eye doctor)?**

- No Yes Don't know

Continued on Next Page

Barcode and Participant ID

[Empty rectangular box for Barcode and Participant ID]

F. CURRENT MEDICINES

32. Are you controlling diabetes through diet or lifestyle modification?

- No
- Yes
- Don't know

33. Are you taking any medicines (including all over-the-counter and prescription pills, skin patches, eye drops, and injections)?

- No
- Yes
- Don't know

If Yes and you do not have kidney failure (dialysis or transplant), please record all current medicines.

Drug Name	

Note: If there are more current medicines than fit on this page, attach an additional copy of this page.

**Family Investigation of Nephropathy and Diabetes (FIND)
Family Pedigree Form**

**Barcode and
Participant ID**

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Date: ____/____/____

Screened by: _____

Name: Last, First, MI	
Address:	
Telephone number:	()-
Clinic/Dialysis Unit Contact physician City/State	

Language preference (please circle): 1) English (2) Spanish (3)Other (specify)_____

1. Date of Birth: _____

2. Gender: Male
 Female

3. Ethnicity: African-American
 Mark all that European-American

Apply

Mexican-American

Other Hispanic (please, specify)_____

Native American

Other (please, specify)_____

4. Do you have any living, blood related relatives with diabetes (siblings/parents)?

No, I am not aware of relatives having diabetes.

I do not know, I am not sure.

Yes, I have relatives with diabetes.

If YES obtain consent to get family information and continue with Table #1

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**Barcode and
Participant ID**

**Table 1 – Grandparent Pedigree
Screening for the FIND Study**

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Last Name				
First Name				
Middle Initial				
Birth Date				
Ethnicity Check all that apply	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____

**Table 2: Family Members Screening for the FIND Study
MALD Screening for Spouse and Child for the FIND Study**

Barcode and Participant ID	
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	Proband	Mother or Spouse	Father or Child	Sib/1	Sib/2
Ethnicity		<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other _____
Barcode ID					
Name/Address/Phone # or note that proband intends to contact this person		<input type="checkbox"/> proband will contact	<input type="checkbox"/> proband will contact	<input type="checkbox"/> proband will contact	<input type="checkbox"/> proband will contact
Current Age					
Gender		FEMALE	MALE		
Diabetes (age at onset or yr of diagnosis) X if not diabetic or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Kidney disease (age at onset or yr of diagnosis) X if no KD or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Hypertension (age at onset or yr of diagnosis) X if no HTN or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Eye disease (age at onset or yr of diagnosis) X if no ED or ? if unknown)	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Does proband think this person will participate ?					
Eligible for FIND (Y or N) if Y give study ID					

Table #2: Extension Page Family Members Screening for the FIND Study

Barcode and Participant ID	
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	Sib/3	Sib/4	Sib/5	Sib/6
Ethnicity	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other	<input type="checkbox"/> African-American <input type="checkbox"/> European-American <input type="checkbox"/> Mexican-American <input type="checkbox"/> Other Hispanic _____ <input type="checkbox"/> Native American <input type="checkbox"/> Other
Barcode ID				
Name/Address/Phone # or note that proband intends to contact this person	<input type="checkbox"/> proband will contact	<input type="checkbox"/> proband will contact	<input type="checkbox"/> proband will contact	<input type="checkbox"/> proband will contact
Current Age				
Gender				
Diabetes (age at onset or yr of diagnosis) X if not diabetic or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Kidney disease (age at onset or yr of diagnosis) X if no KD or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Hypertension (age at onset or yr of diagnosis) X if no HTN or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Eye disease (age at onset or yr of diagnosis) X if no ED or ? if unknown	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____	Age _____ or Year _____
Does proband think this person will participate?				
Eligible for FIND (Y or N) if Y give study ID				

List of Primary Causes of End Stage Renal Disease

FIND Accepted Diabetic Reasons

<u>ICD-9</u>	<u>LTR</u>	<u>Narrative</u>
25000	A	Type II, adult-onset type or unspecified type diabetes
25001	A	Type I, juvenile type, ketosis prone diabetes

FIND Accepted Non-Diabetic Reasons

<u>ICD-9</u>	<u>LTR</u>	<u>Narrative</u>
5829	A	Glomerulonephritis (GN)
5821	A	Focal glomerulosclerosis, focal sclerosing GN
5831	A	Membranous nephropathy
5832	A	Membranoproliferative GN type1, diffuse MPGN
58381	B	IgA nephropathy, Berger's disease (proven by immunofluorescence)
5804	B	Rapidly progressive GN
5834	C	Goodpasture's Syndrome
7100	E	Lupus Erythematosus, (SLE nephritis)
2870	A	Henoch-Schonlein syndrome
7101	B	Scleroderma
4464	B	Wegener's granulomatosis
4462	A	Vasculitis and its datives
4039	D	Renal disease due to hypertension (no primary renal disease) <i>must prove hypertension before diabetes, else PID considered diabetic</i>
5832	C	Dense deposit disease, MPGN type 2
58381	C	IgM nephropathy, (proven by immunofluorescence)
5800	A	Post infectious GN, SBE
5820	A	Other proliferative
2831	A	Hemolytic uremic syndrome
4460	C	Polyarteritis
5839	C	Nephropathy due to heroin abuse and related drugs
5839	B	Secondary GN, other
9659	A	Analgesic abuse
9849	A	Lead nephropathy
5909	A	Nephropathy caused by other agents
27410	A	Gouty nephropathy
58389	B	Chronic interstitial nephritis
58089	A	Acute interstitial nephritis
4401	A	Renal artery stenosis
59381	B	Renal artery occlusion
59381	E	Cholesterol emboli, renal emboli
7598	B	Hereditary/familial nephropathy
28260	A	Sickle cell disease/anemia
28269	A	Sickle cell trait and other sickle cell (Hbs/Hb other)
0429	A	AIDS nephropathy
7999	A	Etiology uncertain

FIND Unacceptable Causes of End Stage Renal Disease

<u>ICD-9</u>	<u>LTR</u>	<u>Narrative</u>
5830	B	Radiation nephritis
5920	C	Nephrolithiasis
5996	A	Acquired obstructive uropathy
5900	C	Chronic pyelonephritis, reflux nephropathy
5929	B	Urolithiasis
2754	A	Nephrocalcinosis
75313	A	Polycystic kidneys, adult type (dominant)
75314	A	Polycystic, infantile (recessive)
75316	A	Medullary cystic disease, including nephronophthisis
7595	A	Tuberous sclerosis
7598	A	Hereditary nephritis, Alport's syndrome
2700	A	Cystinosis
2718	B	Primary oxalosis
2727	A	Fabry's disease
7533	A	Congenital nephritic syndrome
5839	D	Drash syndrome, mesangial sclerosis
7532	A	Congenital obstructive uropathy
7530	B	Renal hypoplasia, dysplasia, oligonephronia
1890	B	Renal tumor (malignant)
1899	A	Urinary tract tumor (malignant)
2230	A	Renal tumor (benign)
2239	A	Urinary tract tumor (benign)
2395	A	Renal tumor (unspecified)
2395	B	Urinary tract tumor (unspecified)
20280	A	Lymphoma of kidneys
2030	A	Multiple myeloma
2030	B	Light chain nephropathy
2773	A	Amyloidosis
99680	A	Complication post bone marrow or other transplant
64620	A	Post partum renal failure
8660	A	traumatic or surgical loss of kidney(s)
5724	A	Hepatorenal syndrome
5836	A	Tubular necrosis (no recovery)
59389	A	Other renal disorders