GoKinD
Genetics of Kidneys in Diabetes Study

Checklist for Proband/ Relatives

This checklist is to be completed by a staff person during the phone call to the proband or relative (parent). It is a guideline to be used to obtain information from volunteers on their status regarding complications of diabetes and their willingness to go to the nearest GoKinD clinic. If the date, time, month or number of months is unknown, use 00. Complete the entire checklist for each person called, regardless of the information you learn. Send original to the COC in the GoKinD mailing.

A. IDENTIFYING INFORMATION

1. Clinic Number: ___ ___ ___
2. Family ID Number: ___ ___ ___ ___ ___ ___ ___ ___
3. Proband/Relative Code: ___ ___
4. Proband/Relative Initials: ___ ___ ___ (F M L)
5. Proband/Relative Birthdate: ___ ___/ ___ ___/ ___ ___ (Month Day Year)
6. Date of this contact: ___ ___/ ___ ___ /___ ___ (Month Day Year)
7. Gender: Male (1) Female (2)
8. Predominant Race/Ethnicity: (Check only one.)

White, not of Hispanic Origin	(1)
Black, not of Hispanic Origin	(2)
Hispanic	(3)
Asian or Pacific Islander	(4)
American Indian or Alaskan Native	(5)
Other	(6)

a) If other, specify: _____

	NO	YES
9. Is the proband/ relative a twin?	(1)	(2)
a) If YES, is the twin identical?	(1)	(2)

b) Please indicate the proband/Relative Code of the twin: ___ ___

B. DIABETES HISTORY (brief): Complete this section for all probands. [If relative does not have diabetes, go to H]

1. What date was diabetes diagnosed? __ __ /__ __ (Mo Yr) Unknown (3)

	NO	YES
2. Have you ever taken oral drugs for diabetes?	(1)	(2)
a) If YES, are you currently taking oral drugs?	(1)	(2)

b) If NO, when did you stop taking oral agents? __ __ /__ __ (Mo Yr) Unknown (3)

	NO	YES
3. Are you currently taking insulin?	(1)	(2)

a) If YES, what is your current regimen of insulin? (answer one):

< 2 Shots (1) Pump (3)
MDI (2) Other (4)

b) If other, specify: _____

4. When did you begin uninterrupted use of insulin? __ __ /__ __ (Mo Yr) Unknown (3)
5. What is your current total daily dose of insulin? ___ ___ ___ units

	NO	YES
6. Are you currently taking oral drugs and insulin?	(1)	(2)

7. Number of episodes of DKA requiring hospitalization in the past YEAR: __ __

8. Number of hospitalizations for hypoglycemia in past YEAR: ___ ___

(Hospitalization implies overnight admission to the hospital; an emergency ward visit that did not result in hospitalization does not apply.)

9. How many times during the past YEAR did the volunteer experience hypoglycemia of such severity that the volunteer:

a) Lost consciousness without seizure ___ ___

b) Lost consciousness with seizure ___ ___

10. On the average, how many times per day does the volunteer monitor his/her blood for glucose? (IF ZERO, WRITE 00) ___ ___

11. Does the volunteer adjust his/her insulin dose based on the results of self blood glucose monitoring? NO (1) YES (2)

C. EYE COMPLICATIONS

Have you ever been told by a health care professional that you have or had:

	NO	YES	UNKNOWN
1. Any diabetes related eye problems?	(1)	(2)	(3)
a) If YES, specify: _____			
2. Laser Treatment for retinopathy?	NO	YES	UNKNOWN
a) Focal Laser Treatment for macular edema	(1)	(2)	(3)
1) Year of First Treatment:		___ ___ ___ ___	
b) Pan-retinal Laser Treatment for retinopathy	(1)	(2)	(3)
1) Year of First Treatment:		___ ___ ___ ___	
3. Impairment of vision?	(1)	(2)	(3)
4. Cataracts?	(1)	(2)	(3)
5. Detached retina?	(1)	(2)	(3)

D. KIDNEY COMPLICATIONS

Have you ever been told by a health care professional that you have or had:

	NO	YES	UNKNOWN
1. Diabetic kidney problems?	(1)	(2)	(3)
2. Protein or albumin in the urine?	(1)	(2)	(3)
a) Year of first protein or albumin in the urine:		___ ___ ___ ___	
3. Have you ever had kidney dialysis?	(1)	(2)	(3)
If yes:			
a) 1st Kidney dialysis?	(1)	(2)	(3)
b) What year? ___ ___ ___ ___			
c) 2nd Kidney dialysis?	(1)	(2)	(3)
d) What year? ___ ___ ___ ___			
e) 3rd Kidney dialysis?	(1)	(2)	(3)
f) What year? ___ ___ ___ ___			
4. Have you ever had a kidney transplant?	(1)	(2)	(3)
If YES:			
a) 1st Kidney transplant?	(1)	(2)	(3)
b) What year? ___ ___ ___ ___			
c) 2nd Kidney transplant?	(1)	(2)	(3)
d) What year? ___ ___ ___ ___			
e) 3rd Kidney transplant?	(1)	(2)	(3)
f) What year ? ___ ___ ___ ___			
5. Have you ever had a pancreas transplant?	(1)	(2)	(3)
If yes:			
a) 1st Pancreas transplant?	(1)	(2)	(3)
b) What year? ___ ___ ___ ___			

E. CARDIOVASCULAR COMPLICATIONS

Have you ever been told by a health care professional that you have or had:

	NO	YES	UNKNOWN
1. Any problems with heart or blood vessels?	(1)	(2)	(3)
a) If YES, specify: _____			
_____			
Have you ever been hospitalized for:	NO	YES	UNKNOWN
2 . Heart pains or angina?	(1)	(2)	(3)
3. Heart attack or myocardial infarction?	(1)	(2)	(3)
a) Year of first myocardial infarction: ___ ___ ___ ___			

	NO	YES	UNKNOWN
4. Coronary bypass surgery or angioplasty?	(1)	(2)	(3)
a) Year of first surgery or angioplasty: ___ ___ ___ ___			
5. Stroke/TIA?	(1)	(2)	(3)
a) Year of first event: ___ ___ ___ ___			
6. High blood pressure?	(1)	(2)	(3)
7. Drug treatment for high blood pressure or hypertension?	(1)	(2)	(3)
a) If YES, are you currently receiving drug treatment?	(1)	(2)	(3)

F. NEUROPATHY

Have you ever been told by a health care professional that you have or had:	NO	YES	UNKNOWN
1. Neuropathy (nerve damage) due to diabetes?	(1)	(2)	(3)
2. Do you have a tingling in your arms or legs?	(1)	(2)	(3)
3. Are you unable to feel your feet when you walk?	(1)	(2)	(3)

G. PERIPHERAL VASCULAR COMPLICATIONS

Have you ever been told by a health care professional that you have or had:	NO	YES	UNKNOWN
1. Any trouble with circulation in legs?	(1)	(2)	(3)
2. Foot ulcers?	(1)	(2)	(3)
3. Gangrene?	(1)	(2)	(3)
Have you ever had:			
4. Non-traumatic amputation?	(1)	(2)	(3)

H. AUTOIMMUNE DISEASES

Have you ever been told by a health care professional that you have or had:

	NO	YES	UNKNOWN
1. Addison's disease	(1)	(2)	(3)
2. Ulcerative colitis	(1)	(2)	(3)
3. Crohn's disease	(1)	(2)	(3)
4. Systemic lupus erythematosus	(1)	(2)	(3)
5. Rheumatoid arthritis	(1)	(2)	(3)
6. Juvenile rheumatoid arthritis	(1)	(2)	(3)
7. Multiple sclerosis	(1)	(2)	(3)
8. Celiac sprue	(1)	(2)	(3)
9. Grave's disease (Hyperthyroid)	(1)	(2)	(3)
10. Hashimoto's disease (Hypothyroid)	(1)	(2)	(3)
11. Pernicious anemia	(1)	(2)	(3)
12. Vitiligo (depigmentation)	(1)	(2)	(3)
13. Alopecia (baldness)	(1)	(2)	(3)
14. Other	(1)	(2)	(3)

a) If other, specify: _____

_____

I. OTHER MAJOR MEDICAL DISEASES

	NO	YES	UNKNOWN
1. Do you have any serious medical problems not mentioned yet?	(1)	(2)	(3)

a) Specify: _____

_____

_____

CONTINUE TO NEXT PAGE

J. WILLINGNESS TO PARTICIPATE

Explain that the next step is to schedule an appointment for the clinical assessments and discuss what time commitment would be necessary. Reiterate general information about the examination. Determine the location of the nearest GoKinD center to this person.

1. How far do you live from the nearest GoKinD clinic? _____ miles

	NO	YES
2. Would you have transportation problems getting to a GoKinD center?	(1)	(2)

a) Specify: _____

3. Will you agree to come to the GoKinD clinic located in

	NO	YES	UNCERTAIN
_____ for the examinations?	(1)	(2)	(3)
a) If NO, would alternative arrangements be acceptable to you?	(1)	(2)	(3)
1. Yes, if remote site	(1)	(2)	
2. Yes, if CTI	(1)	(2)	

4. What times are most convenient for you to come to the center?

_____

_____

_____

5. What times will it be impossible for you to come to the center?

_____

_____

Name of person completing this form:

_____

Certification No. (if any)

___ ___ ___ - ___ ___