Form 005a.10
3/29/01

# GoKinD Study
# Diabetic Offspring

**Lab #:** ***LABNO***

**Joslin Family #:**_____

**Joslin Study #:**_____

**GoKinD ID #:** ***GK_ID***

**PTMR**_____

**Name** _____

**Address** _____

_____

_____

**Male** ***__1__*** **Female** ***__2__*** ***SEX***

**Proband** _____

**Relation to Proband** _____

**Initials** ***INITIALS***

**Birth Date** ***DOB***

**Phone Number** (home) _____

**Today's Date** ***EXAMDATE***

(work*) _____

***optional** – only if you wish to be contacted at work*

**E-mail Address** (optional)_____

## ***Medical History***

1. Do you have diabetes? NO YES ***DIAB***

2. **IF NOT DIABETIC**, Have you ever had diabetes treated by a pancreas transplant? NO YES ***PANTX***

**IF YES TO TRANSPLANT**, Please give the year the transplant was performed: year ***PANTXYR***

**IF YES TO EITHER 1 or 2,** Please give the year of diagnosis of your diabetes: year ***DM_YR***

**IF YES TO EITHER 1 or 2,** What is your current treatment (or treatment at the time or transplant)?

none ***NONE*** diet ***DIET*** oral agents ***ORAL*** insulin ***INSLN***

**IF INSULIN**, when did you start insulin therapy? year ***INS_YR***

**IF INSULIN**, what is your current regimen? ***REGIMEN***

<2 shots ____***1***____ MDI _____***2***___

Pump ____***3***____ Other _____***4***___

**IF INSULIN**, what is your current daily dose (or daily dose at time or transplant)?

***UNITS*** Units

**IF YOU HAVE DIABETES**, do you check your blood sugar levels at home? NO YES ***GLUCHOME***

**IF YES**, how many times a day do you usually check your own blood sugar? ***GLUCCHK***

<1 __***0***__ 1 __***1***__ 2 ___***2***__ 3 ___***3***__ 4+ ___***4***__

**IF YES**, do you adjust your insulin dose based on your blood sugar level? NO YES ***ADJUST***

**IF YES**, at what blood sugar do you feel your best? ***GLUCBEST***

**IF YES** How often, when checked, are you in that range? ***GLUCFREQ***

___***1***____ Less than ½ the time ___***2***____ About ½ the time ____***3***___ More than ½ the time

3. Has a doctor ever said that you have high blood pressure or hypertension? NO YES ***HYPRT***

**IF YES**, please specify year of first diagnosis YEAR ***HYPRTYR***

4.

| | | **IF YES, PLEASE INDICATE YEAR** |
|---|---|---|
| Have you ever had a heart attack? | NO | YES ***HEART*** YEAR ***HRTYR*** |
| Have you ever been hospitalized due to a heart attack? | NO | YES ***HRTHOSP*** YEAR ***HRTHOSPYR*** |
| Have you ever had coronary bypass surgery? | NO | YES ***BYPASS*** YEAR ***BYPASSYR*** |
| Have you ever had angioplasty? | NO | YES ***ANGIO*** YEAR ***ANGIOYR*** |
| Have you ever had a stroke or TIA (transient ischemic attack)? | NO | YES ***STROKE*** YEAR ***STROKEYR*** |

5. Has a doctor ever said that you have retinopathy or eye problems related to diabetes?

NO YES ***RETINO***

**IF YES**, please specify and indicate year of first diagnosis or treatment (if applicable):

| DIAGNOSIS | Yes/No | Year |
|---|---|---|
| Non-Proliferative Retinopathy | ***NPRET*** | ***NPRETYR*** |
| Proliferative Retinopathy | ***PRORET*** | ***PRORETYR*** |
| Laser Treatment | ***LASER*** | ***LASERYR*** |
| Other | ***OTRET*** | ***OTRETYR*** |

**IF LASER TREATMENT IS YES**, what was the laser treatment for: ***LASER_SPEC***

Retinopathy ____***1***_____ Macular Edema _____***2***_____ Unknown _____***3***_____

**IF OTHER**, please specify diagnosis: ***OTRETSPEC***

6. Has a doctor ever said that you have kidney disease (nephropathy) ***related to diabetes***?

NO YES ***RENAL***

**IF YES**, please specify and indicate year of diagnosis or treatment (if applicable):

| DIAGNOSIS | Yes/No | Year |
|---|---|---|
| Microalbuminuria | | |
| Proteinuria | | |
| 1st Dialysis | ***DIAL*** | ***DIALYR*** |
| 1st Renal Transplant | ***TRANS*** | ***TRANSYR*** |
| 2nd Dialysis | | |
| 2nd Renal Transplant | | |
| 3rd Dialysis | | |
| 3rd Renal Transplant | | |

**IF YOU HAVE HAD A KIDNEY TRANSPLANT**,

Was it part of a simultaneous pancreas / kidney transplant? NO YES ***SPK***

6. Has a doctor ever said you have kidney disease that is ***NOT related to diabetes***? NO YES ***KIDOTH***

**IF YES**, please explain: ***KIDOTHSPEC***

_____

_____

_____

7. Has a doctor ever said that you have Peripheral Vascular Disease related to diabetes? NO YES ***PVD***

**IF YES**, please specify and indicate year of first diagnosis or treatment (if applicable):

| DIAGNOSIS | Yes/No | Year |
|---|---|---|
| Claudication | ***CLAUD*** | ***CLAUDYR*** |
| Non-traumatic Amputation | ***AMPUT*** | ***AMPUTYR*** |
| Foot Ulcers | ***FTULCER*** | ***FTULYR*** |
| Gangrene | ***GANG*** | ***GANGYR*** |

8. Have you ever experienced tingling in your feet, hands or legs? NO YES ***TINGLE***

Have you ever experienced numbness in your feet, hands or legs? NO YES ***NUMB***

Has a doctor ever said that you have nerve damage due to diabetes? (neuropathy) NO YES ***NEURO***

9. Have you had any of the following Autoimmune diseases?

| AUTOIMMUNE DISEASE | Yes/No |
|---|---|
| Addison's disease | ***AD_AD*** |
| Ulcerative Colitis | ***AD_UC*** |
| Crohn's Disease | ***AD_CD*** |
| Systemic Lupus Erythematosus | ***AD_SLE*** |
| Rheumatoid Arthritis | ***AD_RA*** |
| Juvenile Rheumatoid Arthritis | ***AD_JRA*** |
| Multiple Sclerosis | ***AD_MS*** |
| Celiac Sprue | ***AD_CS*** |
| Grave's Disease (Hyperthyroid) | ***AD_GD*** |
| Hashimoto's Disease (Hypothyroid) | ***AD_HD*** |
| Pernicious Anemia | ***AD_PA*** |
| Vitiligo | ***AD_V*** |
| Alopecia | ***AD_A*** |
| Other | ***AD_OT*** |

10. Have you had any other diseases, illnesses, or complications? NO YES ***OTHERDIS***

**IF YES**, please specify ***DISSPEC***

## ***Medication***

12. Please list all of your current medication below:

***ACE_M***

***ACE_M2***

***ACE_M3***

***AHTN_M***

***AHTN_M2***

***AHTN_M3***

***DIUR_M***

***DIUR_M2***

***HART_M***

***HART_M2***

***LIP_M***

***GAST_M***

***PSYC_M***

***THYR_M***

***HORM_M***

***OTHER_M1***

***OTHER_M2***

***OTHER_M3***

***OTHER_M4***

***OTHER_M5***

Are you currently taking aspirin regularly? NO YES ***ASPR***

Are you currently taking NSAIDs regularly? (e.g. Motrin, ibuprofen, Nuprin) NO YES ***NSAID***

Are you currently taking vitamin E regularly? NO YES ***VITE***

## ***Cigarette Smoking***

13. Have your ever smoked cigarettes? NO YES ***SMOKE***

**IF NO**, please skip the rest of the smoking questions.

**IF YES**, how old were you when you first started smoking regularly? AGE ***SMOKEAGE***

14. Do you smoke cigarettes now? NO YES ***CURSMOKE***

**IF NO**, how old were you when you last smoked regularly? AGE ***LSTSMOKE***

On average, how many PACKS of cigarettes did you smoke per day during the last month that you smoked regularly? ***PASTPPD***

___*1*___ less than ½ PACK ___*2*___ ½ to 1 PACK

___*3*__ more than 1, but less than 2 PACKS ___*4*___ 2 or more PACKS

**IF YES,** how many PACKS of cigarettes do you smoke per day? ***CURPPD***

___*1*___ less than ½ PACK ___*2*___ ½ to 1 PACK

___*3*__ more than 1, but less than 2 PACKS ___*4*___ 2 or more PACKS

## ***Family History***

***Please complete the following regarding your family's health history***

15. PARENTS

| | YEAR OF BIRTH | **DIABETES?** NO **YES** | **AGE OF ONSET** | HIGH BLOOD PRESSURE? NO YES | LIVING? NO YES | IF DECEASED, YEAR OF DEATH |
|---|---|---|---|---|---|---|
| **FATHER** | ***FYOB*** | ***FDIAB*** | ***FDIABAGE*** | ***FHBLD*** | ***FLIV*** | ***FYOD*** |
| **MOTHER** | ***MYOB*** | ***MDIAB*** | ***MDIABAGE*** | ***MHBLD*** | ***MLIV*** | ***MYOD*** |

We may want to contact your parents to assist us with our research, please indicate their names, addresses, and telephone numbers in the following table.

| | NAME | ADDRESS | PHONE NUMBER |
|---|---|---|---|
| **FATHER** | | | |
| **MOTHER** | | | |

16. SISTERS / BROTHERS

Do you have any brothers or sisters? NO_____ YES_____

**IF YES**, please list your brothers and sisters by year of birth and complete the following table.

| Sib | Year of birth | Sex M/F | Diabetes Y/N | Diabetes Age of onset | Diabetes treatment (none, diet, oral, insulin) | Kidney disease Y/N | Living Y/N |
|---|---|---|---|---|---|---|---|
| 1 | ***SIB#YOB*** | ***SIB#GEND*** | ***SIB#DM*** | ***SIB#AGE*** | ***SIB#TX*** | ***SIB#KID*** | ***SIB#LIV*** |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |

Number of siblings ***SIB_NO***

Number of diabetic siblings ***SIB_DM***

**If any of your brothers or sisters also have diabetes,** we may want to contact him/her/them to assist us with our research. Please indicate their names, addresses, and telephone numbers in the following table.

***SIB#CON***

| Sib | Year of birth | Name | Address | Phone |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |

17. If we would like to contact other siblings in the future, would you be willing to help us locate them?

NO YES ***HELP***

**ORIGIN**

18. Because the incidence of renal complications varies among different populations, please indicate the population you consider yourself to be a member of: (optional)

***ORIGIN***

__*5*___ American Indian or Native American
__*4*___ Asian or Pacific Islander
__*2*___ Black, not of Hispanic Origin
__*3*___ Hispanic
__*1*___ White, not of Hispanic Origin
__*6*___ Other or Unknown

Please indicate the ethnic origin of your father? ***FETH***
Please indicate the ethnic origin of your mother? ***METH***

Please indicate the birthplace of your father (city, country, or region)? _____
Please indicate the birthplace of your mother (city, country, or region)? _____

## *Thank You!*

| | |
|---|---|
| ***ACR_DATE*** | Date of ACR from Medical Record |
| ***ACR_MR*** | ACR value from Medical Record |
| ***ACR_PROT*** | Flag if no ACR value, but ALBUSTX = 2+ (date will still be entered) |
| ***ACR_ESRD*** | Flag if no ACR value because subject has ESRD (date will be left blank) |
| ***ACR_NO_HIST*** | Flag if no ACR value, USCR1 collected from patient |
| ***CC*** | Subjects recruited as a Case or Control |

# Study Status

Name of Subject:_____ Family number:_____

Name of Proband:_____ Study number:_____

Relationship of Subject to Proband:_____ Lab number:_____

| PROCEDURE | DATE | NOTES |
|---|---|---|
| Consent Form | | |
| Questionnaire | | |
| Lab: blood<br>urine | | |
| Results and thank you | | |
| Samples sent to MN: blood<br>urine | | |
| Misc. voucher submitted | | |
| Entered into database | | |

| MEASUREMENT | DATE | NOTES |
|---|---|---|
| Blood Pressure # 1 (sys/dia) ***SYS1/DIA1*** | | |
| Blood Pressure # 2 (sys/dia) ***SYS2/DIA2*** | | |
| Height: ***HEIGHT*** *inches* | | |
| Weight: ***WGHT*** *lbs.* | | |
| Time of urine void: ***VOID*** | | |
| Time of last meal: ***MEAL*** | | |
| Time of blood draw: ***DRAW*** | | |
| Blood glucose: ***BLDGLUC*** | | |