

## GoKinD Study Parents

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proband \_\_\_\_\_

Relation to Proband \_\_\_\_\_

Phone Number (home) \_\_\_\_\_

(work\*) \_\_\_\_\_

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

E-mail Address (optional) \_\_\_\_\_

Lab #: \_\_\_\_\_

Joslin Family #: \_\_\_\_\_

Joslin Study #: \_\_\_\_\_

GoKinD ID #: \_\_\_\_\_

PTMR \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Initials: \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Medical History

1. Do you have diabetes? NO \_\_\_\_\_ YES \_\_\_\_\_

**IF YES,** Please give the year of diagnosis of your diabetes: year \_\_\_\_\_

**IF YES,** What is your current treatment? none \_\_\_\_\_ diet \_\_\_\_\_ oral agents \_\_\_\_\_ insulin \_\_\_\_\_

**IF ON INSULIN,** when did you start insulin therapy? year \_\_\_\_\_

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

<2 shots \_\_\_\_\_ MDI \_\_\_\_\_

Pump \_\_\_\_\_ Other \_\_\_\_\_

**IF ON INSULIN,** what is your current daily dose? \_\_\_\_\_ Units

2. Has a doctor ever said that you have high blood pressure or hypertension?

NO \_\_\_\_\_ YES \_\_\_\_\_

**IF YES,** please specify year of first diagnosis YEAR \_\_\_\_\_

3. Have you ever had a heart attack? NO \_\_\_\_\_ YES \_\_\_\_\_  
**IF YES**, please indicate year of first heart attack YEAR \_\_\_\_\_
- Have you ever been hospitalized due to a heart attack? NO \_\_\_\_\_ YES \_\_\_\_\_  
**IF YES**, please indicate year of first heart attack hospitalization YEAR \_\_\_\_\_
- Have you ever had coronary bypass surgery? NO \_\_\_\_\_ YES \_\_\_\_\_  
**IF YES**, please indicate year of first bypass surgery YEAR \_\_\_\_\_
- Have you ever had angioplasty? NO \_\_\_\_\_ YES \_\_\_\_\_  
**IF YES**, please indicate year of first angioplasty YEAR \_\_\_\_\_
- Have you ever had a stroke or TIA (transient ischemic attack)? NO \_\_\_\_\_ YES \_\_\_\_\_  
**IF YES**, please indicate year of first stroke/TIA YEAR \_\_\_\_\_

4. Has a doctor ever said that you have retinopathy or eye problems related to diabetes?  
 NO \_\_\_\_\_ YES \_\_\_\_\_

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

DIAGNOSIS	Yes/No	Year
Non-Proliferative Retinopathy		
Proliferative Retinopathy		
Laser Treatment		
Other		

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

Retinopathy \_\_\_\_\_ Macular Edema \_\_\_\_\_ Unknown \_\_\_\_\_

**IF OTHER**, please specify diagnosis:

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

NO \_\_\_\_\_ YES \_\_\_\_\_

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

<b>DIAGNOSIS</b>	<b>YES/NO</b>	<b>Year</b>
Microalbuminuria		
Proteinuria		
1 <sup>st</sup> Dialysis		
1 <sup>st</sup> Renal Transplant		
2 <sup>nd</sup> Dialysis		
2 <sup>nd</sup> Renal Transplant		
3 <sup>rd</sup> Dialysis		
3 <sup>rd</sup> Renal Transplant		

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

Was it part of a simultaneous pancreas / kidney transplant?      NO \_\_\_\_\_ YES \_\_\_\_\_

6. Has a doctor ever said you have kidney disease that is ***NOT related to diabetes?***

NO \_\_\_\_\_ YES \_\_\_\_\_

**IF YES**, please explain:

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

<b>Autoimmune Disease</b>	<b>Yes/No</b>
Addison's disease	
Ulcerative Colitis	
Crohn's Disease	
Systemic Lupus Erythematosus	
Rheumatoid Arthritis	
Juvenile Rheumatoid Arthritis	
Multiple Sclerosis	
Celiac Sprue	
Grave's Disease (Hyperthyroid)	
Hashimoto's Disease (Hypothyroid)	
Pernicious Anemia	
Vitiligo	
Alopecia	
Other	

8. Have you had any other diseases, illnesses, or complications? NO \_\_\_ YES \_\_\_

**IF YES**, please specify \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication**

9. Please list all of your current medications below:

<b>Medication Names</b>	

Please provide information about current and past usage of ACE-inhibitors (if not already listed)

\* See attached list of common ACE-inhibitors

<b>Medication name*</b>	<b>Year began</b>	<b>Year Ended (if Not currently Used)</b>	<b>Dose</b>

Please provide information about current usage of other blood pressure medications (if not already listed)

<b>Medication name</b>

Are you currently taking aspirin regularly? NO \_\_\_\_\_ YES \_\_\_\_\_

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

Are you currently taking vitamin E regularly? NO \_\_\_\_\_ YES \_\_\_\_\_

**ORIGIN**

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

\_\_\_\_\_ American Indian or Native American

\_\_\_\_\_ Hispanic

\_\_\_\_\_ Asian or Pacific Islander

\_\_\_\_\_ White, not of Hispanic Origin

\_\_\_\_\_ Black, not of Hispanic Origin

\_\_\_\_\_ Other or Unknown

Please indicate the ethnic origin of your father? \_\_\_\_\_

Please indicate the ethnic origin of your mother? \_\_\_\_\_

Please indicate the birthplace of your father (city, country, or region)? \_\_\_\_\_

Please indicate the birthplace of your mother (city, country, or region)? \_\_\_\_\_

***Thank You!***

## List of common ACE-inhibitors

**Accupril** (Quinapril)

**Aceon** (Peridopril)

**Altace** (Ramipril)

**Avapro** (Irbesartan)

**Capoten** (Captopril)

**Capozide** (Captopril + HCT)

**Cozaar** (Losartan)

**Diovan** (Valsartan)

**Hyzaar** (Losartan + HCT)

**Lexxel** (Elanapril + Felodipine)

**Lotensin** (Benazepril)

**Lotensin HCT** (Benazepril + HCT)

**Lotrel** (Amlodipine + Benazepril)

**Mavik** (Trandolapril)

**Monopril** (Fosinopril)

**Prinivil** (Lisinopril)

**Prinzide** (Lisinopril + HCT)

**Tarka** (Trandolapril + Verapamil)

**Uniretic** (Moexipril + HCT)

**Univasc** (Moexipril)

**Vaseretic** (Elanapril + HCT)

**Vasotec** (Elanapril)

**Zestoretic** (Lisinopril + HCT)

**Zestril** (Lisinopril)