

NATIONAL ANALGESIC NEPHROPATHY STUDY

ESRD PATIENT INTERVIEW

Phase I

**Slone Epidemiology Unit
Boston University School of Medicine**

July 2000

Note: The following is a printed version of the computerized forms that were used for conducting the NANS interview during Phase I. While it contains all of the key elements, it is not an exact representation of the screens or the computer program. For further details of the latter please see the Phase I Manual.

INITIAL INFORMATION

Form ID # _____

Hospital/Dialysis Unit _____

Interviewer ID # _____

____ 1. Case 2. Control

Date of interview ____/____/____

DOB ____/____/____

Sex ____ 1. Male 2. Female

Age ____ (computer generated)

Marital status ____ 1. Married or live-in partner
2. Separated
3. Divorced

4. Widowed
5. Never married
6. No answer

Do you consider yourself white, black or African-American, Asian or Pacific Islander, Native American, or something else?

- White
- Black/African-American
- Asian/Pacific Islander
- Native American
- Something else _____
(Specify)

What is the highest year of school that you have completed?

- Less than 8th grade
- 8th through 11th grade
- 12th grade/high school graduate (include GED)
- Vocational school
- Some college (include 2 year college degree)
- 4 year college degree
- School beyond college
- Unknown

How tall are you without shoes? ____ feet, ____ inches OR _____ centimeters

How much do you currently weigh? _____ pounds, OR _____ kilograms

How much did you weigh 10 years ago? _____ pounds OR _____ kilograms

Diagnosis - Cases Only _____
(from medical record)

Diagnosis code

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

EXCLUSION CRITERIA

Before starting dialysis:

Had you ever been told by a doctor that you had diabetes (sugar diabetes, diabetes mellitus)?

- _____ 1. No
2. Yes
3. Only during pregnancy
9. Unknown
- Date diagnosed _____/_____/_____ Unknown
(Month/Year)

If yes, was the diabetes treated with insulin or pills?

- _____ 1. No
2. Yes
9. Unknown

IF YES - COMPLETE INTERVIEW AND REVIEW DIABETIC STATUS WITH INVESTIGATOR

Did you ever have all or part of a kidney removed?

- _____ 1. No
2. Yes
9. Unknown
- _____/_____/_____ Total nephrectomy
(Month/Year) _____ Partial nephrectomy
(Reason)

IF YES - TERMINATE INTERVIEW

Women <55 years of age

Are you currently pregnant?

- _____ 1. No
2. Yes
9. Unknown

IF YES - TERMINATE INTERVIEW

RENAL HISTORY

When were you told for the first time that you had kidney disease? _____ / _____
(Month/Year)

When did you have your first kidney dialysis? _____ / _____ / _____
(Month/Day/Year)

Before starting dialysis, did a doctor ever tell you that you had:

Albumin or protein in your urine? _____ 1. No
2. Yes _____ / _____
9. Unknown (Month/Year)

Blood in your urine?

_____ 1. No
2. Yes _____ / _____
9. Unknown (Month/Year)

Swelling of the legs, ankles, face, or elsewhere that might be due to kidney disease?

_____ 1. No
2. Yes _____ / _____
9. Unknown (Month/Year)

A blood test that showed you have kidney disease (elevated BUN, creatinine)? _____ 1. No
2. Yes _____ / _____
9. Unknown (Month/Year)

Anemia attributed to kidney disease?

_____ 1. No
2. Yes _____ / _____
9. Unknown (Month/Year)

Before starting dialysis, had you ever been told by a doctor that you had any of the following:

Glomerulonephritis _____ / _____
Month/Year
 Obstructed kidney _____ / _____
 Infections involving your kidney _____ / _____
 Kidney disease due to diabetes _____ / _____

Did a doctor ever tell you that you were born with kidney or urinary problems (such as polycystic kidney disease, double ureter)?

_____ 1. No
2. Yes _____
9. Unknown (Specify)

Before starting dialysis:

Did you experience any of the following:

	No	Yes	Unknown	Date of 1st occurrence (Month/Year)
Change in your pattern of sleep	_____	_____	_____	____/____
Unusual fatigue/tiring easily, lethargy/lassitude	_____	_____	_____	____/____
Change in the taste of food	_____	_____	_____	____/____
Severe loss of appetite for more than 1 week	_____	_____	_____	____/____
Nausea/vomiting that lasted more than 1 week	_____	_____	_____	____/____
Loin pain (the part of the side and back between the ribs and the pelvis)	_____	_____	_____	____/____
Muscle cramps that lasted for more than 1 week	_____	_____	_____	____/____

Did you ever have high blood pressure that required treatment with medication?

- _____ 1. No (*skip to diabetes*)
2. Yes _____ Age HBP diagnosed
3. Only during pregnancy (*skip to other medical history*)
9. Unknown

Had you ever been admitted to the hospital because of high blood pressure?

- _____ 1. No
2. Yes No. of times _____ Years of admission _____
9. Unknown

What is your highest blood pressure that was ever recorded? _____/_____
(systolic/diastolic)

OTHER MEDICAL HISTORY

Before starting dialysis, had you ever been told by a doctor that you had:

	No	Yes	Unknown	Age at diagnosis
Gout or high uric acid	_____	_____	_____	_____
Gastric or duodenal ulcer or gastrointestinal bleeding	_____	_____	_____	_____
Cancer or malignant tumor	_____	_____	_____	
Specify _____ Code _____				_____
Specify _____ Code _____				_____
Other major or chronic illness or a condition requiring surgery	_____	_____	_____	
Specify _____ Code _____				_____
Specify _____ Code _____				_____
Specify _____ Code _____				_____

Has there ever been a period lasting 3 months or more in your life when you had:

1. Frequent headaches or sinus pain?

- _____ 1. No
 _____ 2. Yes
 _____ 9. Unknown

If yes: Year started Frequency Duration
 _____ _____ months, years

(Repeat as necessary)

FREQUENCY CODES

- 1 = Daily
 2 = 4-6 days per week
 3 = 2-3 days per week
 4 = 1 day per week

2. Arthritis, rheumatism, joint pain or back pain?

- _____ 1. No
 _____ 2. Yes
 _____ 9. Unknown

If yes: Year started Frequency Duration
 _____ _____ months, years

(Repeat as necessary)

FREQUENCY CODES

- 1 = Daily
 2 = 4-6 days per week
 3 = 2-3 days per week
 4 = 1 day per week

3. Any other chronic pain condition (e.g., dental pain or fibromyalgia)?

- _____ 1. No
 _____ 2. Yes
 _____ 9. Unknown

If yes: Year started Frequency Duration
 _____ _____ months, years

(Repeat as necessary)

FREQUENCY CODES

- 1 = Daily
 2 = 4-6 days per week
 3 = 2-3 days per week
 4 = 1 day per week

4. Trouble getting through the day?

- ___ 1. No
- ___ 2. Yes
- ___ 9. Unknown

Year started
If yes: _____

Frequency

Duration
 months, years

(Repeat as necessary)

FREQUENCY CODES

- 1 = Daily
- 2 = 4-6 days per week
- 3 = 2-3 days per week
- 4 = 1 day per week

5. Trouble sleeping?

- ___ 1. No
- ___ 2. Yes
- ___ 9. Unknown

Year started
If yes: _____

Frequency

Duration
 months, years

(Repeat as necessary)

FREQUENCY CODES

- 1 = Daily
- 2 = 4-6 days per week
- 3 = 2-3 days per week
- 4 = 1 day per week

ANALGESIC HISTORY

We are interested in obtaining information on any **pain medications** you may have taken on a regular basis; by that I mean, any medicines taken at least once a week for at least 3 months and taken **BEFORE STARTING DIALYSIS**.

These include medicines you may have obtained anywhere, including a doctor's prescription, a hospital or neighborhood clinic, a pharmacy, supermarket, store, friends, neighbors, or relatives.

To help you remember, I'm going to read a list of some medical conditions and the names of some specific medications.

Have you taken any medication at least once a week for at least 3 months for:

PROMPT #1

- A. Pain, headache, backache, toothache, sinus pain, menstrual pain, or stomach pain
- B. Muscle relaxant/spasms or arthritis/joint pain
- C. Gout/high uric acid, swelling or inflammation secondary to injury
- D. Fever, cough/cold, or influenza

PROMPT #2

BEFORE STARTING DIALYSIS, had you ever taken analgesics or pain killers at least once a week for at least 3 months:

- E. For nerves or to reduce stress
- F. To help you sleep
- G. To get through or manage the day
- H. To perk up
- I. To feel better or when you just don't feel well
- J. To treat or prevent hangover
- K. To prevent headaches or other pain
- L. To prevent heart disease
- M. To prevent thrombosis or stroke
- N. To prevent "restless" legs

PROMPT #3

BEFORE STARTING DIALYSIS, had you ever taken any of the following products at least once a week for at least 3 months (read attached list):

PROMPT #4

BEFORE STARTING DIALYSIS, was there any other pain medication you took at least once a week for at least 3 months that we have not asked about?

TRADE NAME LIST

ACETAMINOPHEN	INDOCIN
ADVIL	LIQUIPRIN
ALEVE	MIDOL or MIDOL IB
ALKA SELTZER	MOTRIN or MOTRIN IB
ANACIN	NAPROSYN
ANAPROX	NAPROXEN
ASCRIPTIN	NORGESIC or NORGESIC FORTE
ASPIRIN	NUPRIN
BC POWDER	NYQUIL
BROMO SELTZER	NYTOL
BUFFERIN	ORUDIS
CLINORIL	PAMPRIN
COPE	PARAFON FORTE
CORICIDIN	PEPTO-BISMOL
DARVOCET	PERCODAN
DARVON	ROBAXISAL
DOAN'S	RUFEN
DRISTAN	SINE-AID
ECOTRIN	SINE-OFF
EMPIRIN	SOMA COMPOUND
EMPIRIN with CODEINE	SOMINEX
EQUAGESIC	STANBACK POWDERS
EXCEDRIN	SYNALGOS-DC CAPSULES
FELDENE	TALWIN COMPOUND
FIORICET	TYLENOL
FIORINAL	VANQUISH
GOODYS POWDER	VOLTAREN
IBUPROFEN	

Prompt # _____

Drug name _____

Drug code

Drug Book

Prompt #	Year started	If unknown, year range	Frequency	Average # pills/doses per day	If unknown, pill range	Duration	Duration unknown	Reason for use	
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>

Prompt # _____

Drug name _____

Drug code

Drug Book

Prompt #	Year started	If unknown, year range	Frequency	Average # pills/doses per day	If unknown, pill range	Duration	Duration unknown	Reason for use	
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>
_____	_____	_____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - <input type="checkbox"/>	_____ <input type="checkbox"/> months, <input type="checkbox"/> years	<input type="checkbox"/>	_____ <i>(Specify)</i>	_____ <i>(Code)</i>

FREQUENCY CODES

- 1 = Daily
- 2 = 4-6 days per week
- 3 = 2-3 days per week
- 4 = 1 day per week

Did your doctor or medical practitioner advise you to discontinue use of any pain medications based on a problem with your kidneys or the results of kidney tests?

- ___ 1. No
- ___ 2. Yes
- ___ 9. Unknown

If yes, what was the name of the medication?

--	--	--	--	--	--

Drug code

When this was recommended, did you:

- ___ 1. Stop taking it and start something else?
- ___ 2. Stop taking it without starting another pain medication?
- ___ 3. Continue to take the medication?
- ___ 9. Unknown

Year stopped

Drug name

--	--	--	--	--	--

Drug code

Year stopped

Was there any other medication your doctor advised you to discontinue because of your kidneys?

- ___ 1. No
- ___ 2. Yes
- ___ 9. Unknown

If yes, what was the name of the medication?

--	--	--	--	--	--

Drug code

When this was recommended, did you:

- ___ 1. Stop taking it and start something else?
- ___ 2. Stop taking it without starting another pain medication?
- ___ 3. Continue to take the medication?
- ___ 9. Unknown

Year stopped

Drug name

--	--	--	--	--	--

Drug code

Year stopped

HABITS

Have you ever smoked cigarettes, cigars, or a pipe? _____ 1. No (*skip to next page*) 9. Unknown (*skip to next page*)
2. Yes

Have you smoked at least 100 cigarettes in your life? _____ 1. No (*skip to pipe*) 9. Unknown (*skip to pipe*)
2. Yes

Did you smoke cigarettes during the year before starting dialysis? _____ 1. No 9. Unknown
2. Yes

For ex-smoker, time since stopping: _____ years

For current or ex-smoker, years duration _____
number of cigarettes per day _____
age started smoking _____

Have you smoked a pipe at least 50 times in your entire life? _____ 1. No (*skip to cigars*) 9. Unknown (*skip to cigars*)
2. Yes

Did you smoke a pipe during the year before starting dialysis? _____ 1. No 9. Unknown
2. Yes

For ex-smoker, time since stopping: _____ years

For current or ex-smoker, years duration _____
number of pipefuls per day _____
age started smoking _____

Have you smoked at least 50 cigars in your life? _____ 1. No (*skip to alcohol*) 9. Unknown (*skip to alcohol*)
2. Yes

Did you smoke a cigar during the year before starting dialysis? _____ 1. No 9. Unknown
2. Yes

For ex-smoker, time since stopping: _____ years

For current or ex-smoker, years duration _____
number of cigars per day _____
age started smoking _____

Before starting dialysis, how often did you drink:

	Frequency	Number per day
Decaffeinated coffee	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Regular coffee	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Regular tea	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Beer	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Wine	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Liquor	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Home distilled alcohol or moonshine	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Drinking pattern at age 30:

	Frequency	Number per day
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

FREQUENCY CODES

- 1 = Daily
- 2 = 4-6 days per week
- 3 = 1-3 days per week
- 4 = 1 or more days per month
- 5 = Less than once a month
- 6 = Ex-drinker for over 1 year
- 7 = Never
- 8 = Changed habits during past year
- 9 = Unknown

OCCUPATION

Now I would like to ask some questions about your employment history.

List all the jobs or occupations you have held for at least one year, starting with the most recent.

Job title	Industry code	Occupation code	# of years	year started
	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>

Task _____

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Task _____

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Task _____

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Task _____

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Task _____

INCOME

1. In general, would you say that your total annual household income is more or less than \$20,000?

- More Unknown (*skip to next page*)
 Less (*skip to 5*) Refused (*skip to next page*)

2. Would you say that your total annual household income is more or less than \$35,000?

- More Unknown (*skip to next page*)
 Less (*skip to 6*) Refused (*skip to next page*)

3. Would you say that your total annual household income is more or less than \$65,000?

- More Unknown (*skip to next page*)
 Less (*skip to 6*) Refused (*skip to next page*)

4. Would you say that your total annual household income is more or less than \$100,000?

- More (*skip to 6*) Unknown (*skip to next page*)
 Less (*skip to 6*) Refused (*skip to next page*)

5. Would you say that your total annual household income is more or less than \$10,000?

- More Unknown (*skip to next page*)
 Less Refused (*skip to next page*)

6. How many persons are dependent on that income? _____

MISCELLANEOUS INFORMATION

Finally, I'd like to ask about any experiences with recreational drugs before starting dialysis. Please remember that everything you tell us will remain strictly confidential.

Have you ever used any of the following at least 50 times?	No	Yes	Unknown	Refused
Marijuana (grass, pot, hashish)	_____	_____	_____	_____
Amphetamines (speed, uppers, stimulants)	_____	_____	_____	_____
Cocaine or crack	_____	_____	_____	_____
Heroin	_____	_____	_____	_____
Psychedelics (LSD, PCP, mescaline)	_____	_____	_____	_____
Other opiates or narcotics	_____	_____	_____	_____

Thank you so much for taking the time to answer our questions. Your information is important to our research and we very much appreciate your participation.

Source of information _____

1. Subject
2. Caretaker (leave note)
3. Surrogate (leave note)
4. Translator
9. Unknown

Reliability _____

1. Reliable
2. Unreliable
9. Unknown

