

# HBDI FAMILY RESOURCE QUESTIONNAIRE FOR THE GENETICS OF TYPE 1 DIABETES

## Section I: Contact Information

|   |              |
|---|--------------|
| <b>Primary Family Contact (<i>the person filling out this questionnaire</i>):</b> |              |
| Name ( <i>First, Last</i> ):  | Maiden Name: |
| Address:  |              |
|   |              |
| Phone:  | Cell Phone:  |
| E-mail:   | Fax:         |

I, \_\_\_\_\_, agree to release the enclosed information to the HBDI.  
HBDI may release my coded, anonymous information to approved diabetes researchers.

The information in this questionnaire is valuable to research only if it is exact and recorded neatly. Please type or print wherever possible.

|                  |             |
|------------------|-------------|
| <b>Signature</b> | <b>Date</b> |
|------------------|-------------|

## Section II: HBDI Family Profiles

### Primary Family Profile

*Instructions:*

Please complete the tables on pages 2-6 that ask questions about your immediate family, your maternal family (mother's parents and siblings), your paternal family (father's parents and siblings) and members of your immediate family who have children with diabetes. Please only record family members who are related by blood (for example, members of the family who are adopted do not need to be mentioned). We are interested in information about all blood relatives.

Please summarize your family history below:

|  |
|--|
| Number of members in your primary family profile (to be outlined on page 3): |
| Number of parents with Type 1 diabetes in the primary family profile:        |
| Number of children with Type 1 diabetes in the primary family profile:       |

Most of the families associated with the HBDI were originally recruited from 1988 to 1993, and participants defined as "children" in your family may now have children of their own. Information about grandchildren may be provided below. An adult child who has children may request or be asked to complete an additional questionnaire in which they are characterized as a parent rather than a child.

|   |          |
|---|----------|
| Do any of the adult children in your family have children? <input type="checkbox"/> Yes <input type="checkbox"/> No |          |
| <i>If so, please list the grandchild, whether or not they have diabetes and parent's contact information.</i>       |          |
| Name of Grandchild:   | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2  |          |
| Diabetes onset age:   | Phone:   |
| Birth date:   |          |
| Mother's Name:  | Cell:    |
| Father's Name:  | E-mail:  |
| Name of Grandchild:   | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2  |          |
| Diabetes onset age:   | Phone:   |
| Birth date:   |          |
| Mother's Name:  | Cell:    |
| Father's Name:  | E-mail:  |
| Name of Grandchild:   | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2  |          |
| Diabetes onset age:   | Phone:   |
| Birthdate:  |          |
| Mother's Name:  | Cell:    |
| Father's Name:  | E-mail:  |

|  |          |
|--|----------|
| Name of Grandchild:  | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2 |          |
| Diabetes onset age:  | Phone:   |
| Birthdate:   |          |
| Mother's Name:   | Cell:    |
| Father's Name:   | E-mail:  |
| Name of Grandchild:  | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2 |          |
| Diabetes onset age:  | Phone:   |
| Birthdate:   |          |
| Mother's Name:   | Cell:    |
| Father's Name:   | E-mail:  |
| Name of Grandchild:  | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2 |          |
| Diabetes onset age:  | Phone:   |
| Birthdate:   |          |
| Mother's Name:   | Cell:    |
| Father's Name:   | E-mail:  |
| Name of Grandchild:  | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2 |          |
| Diabetes onset age:  | Phone:   |
| Birthdate:   |          |
| Mother's Name:   | Cell:    |
| Father's Name:   | E-mail:  |
| Name of Grandchild:  | Address: |
| Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Not Diabetic<br><input type="checkbox"/> Type 2 |          |
| Diabetes onset age:  | Phone:   |
| Birthdate:   |          |
| Mother's Name:   | Cell:    |
| Father's Name:   | E-mail:  |

*Please list additional grandchildren on the back of this form or attach an additional sheet if necessary. If there are a large number of grandchildren in your family and completion of this information is too time consuming, please focus on the children of any diabetics in the family and any grandchildren diagnosed with diabetes.*

## Primary Family Profile

| Full Name (First, Last) | Sex | Birth date (mm/dd/yy) | Alive? Yes or No | Age | Height ft. | Height in. | Weight lbs. | Diabetes Status (Please check one)  | Current Diabetes Treatment (Please check all that apply)   | Age of Diabetes Diagnosis | Age Insulin First Used |
|-------------------------|-----|-----------------------|------------------|-----|------------|------------|-------------|---|--|---------------------------|------------------------|
| Mother                  | F   |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| Father                  | M   |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| First Child             |     |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| Second Child            |     |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| Third Child             |     |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| Fourth Child            |     |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| Fifth Child             |     |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |
| Sixth Child**           |     |                       |                  |     |            |            |             | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                           |                        |

\*Gestational diabetes is a type of diabetes that occurs only during pregnancy. \*\*Please use the back of this sheet or attach additional pages if more space is needed.

## Mother's Family – Maternal

| Full Name (First, Last) | Sex | Birth date (mm/dd/yy) | Alive? Yes or No | Age | Diabetes Status (Please check one)  | Current Diabetes Treatment (Please check all that apply)   | Age at Onset of Diabetes | Age Insulin First Used |
|-------------------------|-----|-----------------------|------------------|-----|---|--|--------------------------|------------------------|
| Grandmother             | F   |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Grandfather             | M   |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Cousin                  |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Cousin**                |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |

\*Gestational diabetes is a type of diabetes that occurs only during pregnancy. \*\*Please use the back of this sheet or attach additional pages if more space is needed.

### Father's Family – Paternal

| Full Name (First, Last) | Sex | Birth date (mm/dd/yy) | Alive? Yes or No | Age | Diabetes Status (Please check one)  | Current Diabetes Treatment (Please check all that apply)   | Age at Onset of Diabetes | Age Insulin First Used |
|-------------------------|-----|-----------------------|------------------|-----|---|--|--------------------------|------------------------|
| Grandmother             | F   |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Grandfather             | M   |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Uncle/Aunt              |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Cousin                  |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |
| Cousin**                |     |                       |                  |     | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Borderline<br><input type="checkbox"/> Gestational*<br><input type="checkbox"/> Not Diabetic | <input type="checkbox"/> Insulin Injection<br><input type="checkbox"/> Insulin Pump<br><input type="checkbox"/> Tablet/Pill<br><input type="checkbox"/> Diet Only<br><input type="checkbox"/> Other: _____ |                          |                        |

\*Gestational diabetes is a type of diabetes that occurs only during pregnancy. \*\*Please use the back of this sheet or attach additional pages if more space is needed.

**Section III. Parents' and Grandparents' Ethnic Origins and Country of Birth**  
**Please find your ethnic origin code numbers and insert in the family table below:**

**Ethnic Origin Code Number**

| <b>Ethnic Origin</b>                     | <b>Number</b> |
|--|---------------|
| African                                  | 01            |
| African American, not of Hispanic Origin | 02            |
| Anglo-Saxon (English, Wales, Ireland)    | 03            |
| Arab                                     | 04            |
| Persian                                  | 05            |
| Asian, North and East (China)            | 06            |
| Asian, South and West (Indian)           | 07            |
| European East, Slavic                    | 08            |
| European North (Norway, Scandinavian)    | 09            |
| European West (France, Germany)          | 10            |
| Hispanic – South American                | 11            |
| Hispanic – Mexican                       | 12            |
| Hispanic – Puerto Rican                  | 13            |
| Spanish/Portuguese                       | 14            |
| Caribbean Islander                       | 15            |
| Jewish, Ashkenazi                        | 16            |
| Jewish, Other                            | 17            |
| Jewish, Sephardim                        | 18            |
| Mediterranean (Italy, Greece, Spain)     | 19            |
| Native American/ Alaskan Native          | 20            |
| Pacific Islander                         | 21            |
| Russian                                  | 22            |
| Other, Specify:                          | 88            |
| Unknown                                  | 99            |

| <b><i>Family Table – Maternal</i></b><br><b>“Mother’s Family” Ethnic and Country Origin Name</b> | <b>Ethnic Origin Code(s) #</b> | <b>City/Country of Birth</b> |
|--|--------------------------------|------------------------------|
| Mother (same as page 4)  |                                |                              |
| Mother’s Maternal Grandmother  |                                |                              |
| Mother’s Maternal Grandfather  |                                |                              |
| Mother’s Paternal Grandmother  |                                |                              |
| Mother’s Paternal Grandfather  |                                |                              |
| <b><i>Family Table – Paternal</i></b><br><b>“Father’s Family” Ethnic and Country Origin Name</b> | <b>Ethnic Origin Code(s) #</b> | <b>City/Country of Birth</b> |
| Father (same as page 4)  |                                |                              |
| Father’s Maternal Grandmother  |                                |                              |
| Father’s Maternal Grandfather  |                                |                              |
| Father’s Paternal Grandmother  |                                |                              |
| Father’s Paternal Grandfather  |                                |                              |

## Section IV. Family Medical History

Instructions: Please include information about yourself and your family members in the following tables. Please include name and year of birth to help us identify you or your family member.

| 1. Do you have multiple births in your immediate family (as detailed on page 4)? <span style="float: right;">☐ Yes   ☐ No</span> |               |   |   |   |   |
|--|---------------|---|---|---|---|
| <i>If so, please check type and complete the table below for each member of multiple birth groups:</i>                           |               |   |   |   |   |
| First Name   | Year of Birth | Multiple Birth Group Size   | Type of Multiple Births   | Alive (Y or N)  | Diabetes  |
|  |               | <input type="checkbox"/> Twins<br><input type="checkbox"/> Triplets<br><input type="checkbox"/> Quadruplets<br><input type="checkbox"/> Other, please specify:<br>_____ | <input type="checkbox"/> Identical<br><input type="checkbox"/> Fraternal<br><input type="checkbox"/> Don't know | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Not Diabetic |
|  |               | <input type="checkbox"/> Twins<br><input type="checkbox"/> Triplets<br><input type="checkbox"/> Quadruplets<br><input type="checkbox"/> Other, please specify:<br>_____ | <input type="checkbox"/> Identical<br><input type="checkbox"/> Fraternal<br><input type="checkbox"/> Don't know | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Not Diabetic |
|  |               | <input type="checkbox"/> Twins<br><input type="checkbox"/> Triplets<br><input type="checkbox"/> Quadruplets<br><input type="checkbox"/> Other, please specify:<br>_____ | <input type="checkbox"/> Identical<br><input type="checkbox"/> Fraternal<br><input type="checkbox"/> Don't know | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Not Diabetic |
|  |               | <input type="checkbox"/> Twins<br><input type="checkbox"/> Triplets<br><input type="checkbox"/> Quadruplets<br><input type="checkbox"/> Other, please specify:<br>_____ | <input type="checkbox"/> Identical<br><input type="checkbox"/> Fraternal<br><input type="checkbox"/> Don't know | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2<br><input type="checkbox"/> Not Diabetic |

| 2. Was the onset of diabetes in your family members preceded by a disease such as the flu, measles, rubella, <span style="float: right;">☐ Yes   ☐ No</span><br>mumps, chicken pox, etc. or by vaccination? <i>If so, please list the family member and the disease or vaccination.</i> |               |  |                        |
|---|---------------|--|------------------------|
| First Name  | Year of Birth | Type of Diabetes   | Disease or Vaccination |
|   |               | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2 |                        |
|   |               | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2 |                        |
|   |               | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2 |                        |
|   |               | <input type="checkbox"/> Type 1<br><input type="checkbox"/> Type 2 |                        |

3. Do any members of your immediate family  
 4. have any of the diseases listed below? ☐ Yes ☐ No  
*If so, please list the family member(s), check if they have diabetes or not and check all the disease(s) that apply.*

|   |   |   |   |
|---|---|---|---|
| First Name:<br>Year of Birth:                           | First Name:<br>Year of Birth:                           | First Name:<br>Year of Birth:                           | First Name:<br>Year of Birth:                           |
| Diabetes: <span style="float: right;">☐ Yes ☐ No</span> | Diabetes: <span style="float: right;">☐ Yes ☐ No</span> | Diabetes: <span style="float: right;">☐ Yes ☐ No</span> | Diabetes: <span style="float: right;">☐ Yes ☐ No</span> |

|  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Addison's Disease<br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Congenital Rubella<br><input type="checkbox"/> Crohn's Disease<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Down's Syndrome<br><input type="checkbox"/> Graves' Disease (hyperthyroid)<br><input type="checkbox"/> Hashimoto's Thyroiditis (hypothyroid)<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Myasthenia Gravis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Scleroderma<br><input type="checkbox"/> Other, please specify:<br><hr style="width: 100%;"/> | <input type="checkbox"/> Addison's Disease<br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Congenital Rubella<br><input type="checkbox"/> Crohn's Disease<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Down's Syndrome<br><input type="checkbox"/> Graves' Disease (hyperthyroid)<br><input type="checkbox"/> Hashimoto's Thyroiditis (hypothyroid)<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Myasthenia Gravis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Scleroderma<br><input type="checkbox"/> Other, please specify:<br><hr style="width: 100%;"/> | <input type="checkbox"/> Addison's Disease<br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Congenital Rubella<br><input type="checkbox"/> Crohn's Disease<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Down's Syndrome<br><input type="checkbox"/> Graves' Disease (hyperthyroid)<br><input type="checkbox"/> Hashimoto's Thyroiditis (hypothyroid)<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Myasthenia Gravis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Scleroderma<br><input type="checkbox"/> Other, please specify:<br><hr style="width: 100%;"/> | <input type="checkbox"/> Addison's Disease<br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Congenital Rubella<br><input type="checkbox"/> Crohn's Disease<br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Down's Syndrome<br><input type="checkbox"/> Graves' Disease (hyperthyroid)<br><input type="checkbox"/> Hashimoto's Thyroiditis (hypothyroid)<br><input type="checkbox"/> Lupus<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Myasthenia Gravis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Scleroderma<br><input type="checkbox"/> Other, please specify:<br><hr style="width: 100%;"/> |
|--|--|--|--|

*For each disease listed above, please indicate the disease, age at diagnosis (dx) and the name and dose of medications taken for that disease (if known). Please list the medication name(s) as written on the medication vial.*

|             |             |             |             |
|-------------|-------------|-------------|-------------|
| Disease:    | Disease:    | Disease:    | Disease:    |
| Age at dx:  | Age at dx:  | Age at dx:  | Age at dx:  |
| Medication: | Medication: | Medication: | Medication: |
| Dose:       | Dose:       | Dose:       | Dose:       |

|  |  |  |  |
|--|--|--|--|
| Disease:<br>Age at dx:<br>Medication:<br>Dose: | Disease:<br>Age at dx:<br>Medication:<br>Dose: | Disease:<br>Age at dx:<br>Medication:<br>Dose: | Disease:<br>Age at dx:<br>Medication:<br>Dose: |
|--|--|--|--|

5. Has a doctor ever told any members of your family that they have diabetic retinopathy (eye disease)?  Yes  No  Don't know  
*If so, please check all diagnoses that apply and provide age of diagnosis (dx) for each condition checked.*

| First Name:<br>Year of Birth:   | First Name:<br>Year of Birth:   | First Name:<br>Year of Birth:   | First Name:<br>Year of Birth:   |
|---|---|---|---|
| <input type="checkbox"/> a. Diabetic retinopathy<br>- Age at dx:<br><input type="checkbox"/> b. Non-proliferative (NPDR)<br>(background) retinopathy<br>- Age at dx:<br><input type="checkbox"/> c. Proliferative retinopathy (PDR)<br>- Age at dx:<br><input type="checkbox"/> d. Macular Edema<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx:<br><input type="checkbox"/> f. Don't know | <input type="checkbox"/> a. Diabetic retinopathy<br>- Age at dx:<br><input type="checkbox"/> b. Non-proliferative (NPDR)<br>(background) retinopathy<br>- Age at dx:<br><input type="checkbox"/> c. Proliferative retinopathy (PDR)<br>- Age at dx:<br><input type="checkbox"/> d. Macular Edema<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx:<br><input type="checkbox"/> f. Don't know | <input type="checkbox"/> a. Diabetic retinopathy<br>- Age at dx:<br><input type="checkbox"/> b. Non-proliferative (NPDR)<br>(background) retinopathy<br>- Age at dx:<br><input type="checkbox"/> c. Proliferative retinopathy (PDR)<br>- Age at dx:<br><input type="checkbox"/> d. Macular Edema<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx:<br><input type="checkbox"/> f. Don't know | <input type="checkbox"/> a. Diabetic retinopathy<br>- Age at dx:<br><input type="checkbox"/> b. Non-proliferative (NPDR)<br>(background) retinopathy<br>- Age at dx:<br><input type="checkbox"/> c. Proliferative retinopathy (PDR)<br>- Age at dx:<br><input type="checkbox"/> d. Macular Edema<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx:<br><input type="checkbox"/> f. Don't know |

6. Have any members of your family had surgery to control the progression of retinopathy?  Yes  No  Don't know  
*If so, please specify type of surgery, number of surgeries and approximate date of each surgery.*

| First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  |
|--|--|--|--|
| <input type="checkbox"/> a. Laser surgery<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> b. Panretinal photocoagulation?<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> c. Vitrectomy?<br>- How many times:<br>- Date(s) of surgery: | <input type="checkbox"/> a. Laser surgery<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> b. Panretinal photocoagulation?<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> c. Vitrectomy?<br>- How many times:<br>- Date(s) of surgery: | <input type="checkbox"/> a. Laser surgery<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> b. Panretinal photocoagulation?<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> c. Vitrectomy?<br>- How many times:<br>- Date(s) of surgery: | <input type="checkbox"/> a. Laser surgery<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> b. Panretinal photocoagulation?<br>- How many times:<br>- Date(s) of surgery:<br><input type="checkbox"/> c. Vitrectomy?<br>- How many times:<br>- Date(s) of surgery: |

| 7. Do any members of your family experience complete or partial blindness in either eye? <span style="float: right;">☐ Yes ☐ No ☐ Don't know</span><br><i>If so, please specify whether blindness is partial or complete in the right, left or both eyes and age at diagnosis (dx).</i> |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| First Name:<br>Year of Birth:   |  | First Name:<br>Year of Birth:  |  | First Name:<br>Year of Birth:  |  | First Name:<br>Year of Birth:  |  |
| a. Partial blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes   | Age at dx:<br>a. _____<br>b. _____<br>c. _____ | a. Partial blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes  | Age at dx:<br>a. _____<br>b. _____<br>c. _____ | a. Partial blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes  | Age at dx:<br>a. _____<br>b. _____<br>c. _____ | a. Partial blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes  | Age at dx:<br>a. _____<br>b. _____<br>c. _____ |
| b. Complete blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes  | Age at dx:<br>a. _____<br>b. _____<br>c. _____ | b. Complete blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes | Age at dx:<br>a. _____<br>b. _____<br>c. _____ | b. Complete blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes | Age at dx:<br>a. _____<br>b. _____<br>c. _____ | b. Complete blindness<br>☐ a. Right eye<br>☐ b. Left eye<br>☐ c. Both eyes | Age at dx:<br>a. _____<br>b. _____<br>c. _____ |

| 8. Has a doctor ever told any members of your family that they have diabetic neuropathy (nerve disease)? <span style="float: right;">☐ Yes ☐ No ☐ Don't know</span><br><i>If so, please specify type(s) of neuropathy, age diagnosed and medications taken.</i> |                     |                               |                     |                               |                     |                               |                     |
|---|---------------------|-------------------------------|---------------------|-------------------------------|---------------------|-------------------------------|---------------------|
| First Name:<br>Year of Birth:   |                     | First Name:<br>Year of Birth: |                     | First Name:<br>Year of Birth: |                     | First Name:<br>Year of Birth: |                     |
| Type of neuropathy:   | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: |
| Age at diagnosis:   | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   |
| Medication/dose:  | Medication/dose:    | Medication/dose:              | Medication/dose:    | Medication/dose:              | Medication/dose:    | Medication/dose:              | Medication/dose:    |
| Type of neuropathy:   | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: |
| Age at diagnosis:   | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   |
| Medication/dose:  | Medication/dose:    | Medication/dose:              | Medication/dose:    | Medication/dose:              | Medication/dose:    | Medication/dose:              | Medication/dose:    |
| Type of neuropathy:   | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: | Type of neuropathy:           | Type of neuropathy: |
| Age at diagnosis:   | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   | Age at diagnosis:             | Age at diagnosis:   |
| Medication/dose:  | Medication/dose:    | Medication/dose:              | Medication/dose:    | Medication/dose:              | Medication/dose:    | Medication/dose:              | Medication/dose:    |

| 9. Have any members of your family had urine albumin tests for nephropathy (kidney disease)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know<br><i>If so, please specify if the result was positive or negative and details concerning date of detection and albumin level.</i> |   |   |   |
|--|---|---|---|
| First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:   | First Name:<br>Year of Birth:   | First Name:<br>Year of Birth:   |
| Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative  | Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative |
| Date of most recent test:  | Date of most recent test:   | Date of most recent test:   | Date of most recent test:   |
| Year detected ( <i>if applicable</i> ):  | Year detected ( <i>if applicable</i> ):                                     | Year detected ( <i>if applicable</i> ):                                     | Year detected ( <i>if applicable</i> ):                                     |
| Albumin level ( <i>if positive</i> ):  | Albumin level ( <i>if positive</i> ):                                       | Albumin level ( <i>if positive</i> ):                                       | Albumin level ( <i>if positive</i> ):                                       |

| 10. Has a doctor ever told any members of your family that they have a kidney problem as a result of their diabetes? <i>If so, please check all conditions that apply for each member of your family.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |  |  |  |
|--|--|--|--|
| First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  |
| <input type="checkbox"/> a. Protein in urine<br>- Age at dx:   | <input type="checkbox"/> a. Protein in urine<br>- Age at dx:               | <input type="checkbox"/> a. Protein in urine<br>- Age at dx:               | <input type="checkbox"/> a. Protein in urine<br>- Age at dx:               |
| <input type="checkbox"/> b. Nephropathy (kidney disease)<br>- Age at dx:   | <input type="checkbox"/> b. Nephropathy (kidney disease)<br>- Age at dx:   | <input type="checkbox"/> b. Nephropathy (kidney disease)<br>- Age at dx:   | <input type="checkbox"/> b. Nephropathy (kidney disease)<br>- Age at dx:   |
| <input type="checkbox"/> c. End stage renal disease (ESRD)<br>- Age at dx:   | <input type="checkbox"/> c. End stage renal disease (ESRD)<br>- Age at dx: | <input type="checkbox"/> c. End stage renal disease (ESRD)<br>- Age at dx: | <input type="checkbox"/> c. End stage renal disease (ESRD)<br>- Age at dx: |
| <input type="checkbox"/> d. Kidney failure<br>- Age at dx:   | <input type="checkbox"/> d. Kidney failure<br>- Age at dx:                 | <input type="checkbox"/> d. Kidney failure<br>- Age at dx:                 | <input type="checkbox"/> d. Kidney failure<br>- Age at dx:                 |
| <input type="checkbox"/> e. Dialysis<br>- Age at dx:<br>- Duration:  | <input type="checkbox"/> e. Dialysis<br>- Age at dx:<br>- Duration:        | <input type="checkbox"/> e. Dialysis<br>- Age at dx:<br>- Duration:        | <input type="checkbox"/> e. Dialysis<br>- Age at dx:<br>- Duration:        |
| <input type="checkbox"/> f. Kidney transplant<br>- Age at dx:  | <input type="checkbox"/> f. Kidney transplant<br>- Age at dx:              | <input type="checkbox"/> f. Kidney transplant<br>- Age at dx:              | <input type="checkbox"/> f. Kidney transplant<br>- Age at dx:              |
| <input type="checkbox"/> g. Other, please specify:<br><br>_____  | <input type="checkbox"/> g. Other, please specify:<br><br>_____            | <input type="checkbox"/> g. Other, please specify:<br><br>_____            | <input type="checkbox"/> g. Other, please specify:<br><br>_____            |
| - Age at dx:   | - Age at dx:   | - Age at dx:   | - Age at dx:   |

| 11. Have any members of your family had heart, liver, pancreas or islet cell transplants? <span style="float: right;">☐ Yes ☐ No ☐ Don't know</span> |  |  |  |
|--|--|--|--|
| <i>If so, please specify type and number of transplant and approximate date of each transplant.</i>  |  |  |  |
| First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  |
| ☐ a. Heart transplant<br>- How many times:<br>- Date(s) of surgery:  | ☐ a. Heart transplant<br>- How many times:<br>- Date(s) of surgery:      | ☐ a. Heart transplant<br>- How many times:<br>- Date(s) of surgery:      | ☐ a. Heart transplant<br>- How many times:<br>- Date(s) of surgery:      |
| ☐ b. Liver transplant<br>- How many times:<br>- Date(s) of surgery:  | ☐ b. Liver transplant<br>- How many times:<br>- Date(s) of surgery:      | ☐ b. Liver transplant<br>- How many times:<br>- Date(s) of surgery:      | ☐ b. Liver transplant<br>- How many times:<br>- Date(s) of surgery:      |
| ☐ c. Pancreas transplant<br>- How many times:<br>- Date(s) of surgery:   | ☐ c. Pancreas transplant<br>- How many times:<br>- Date(s) of surgery:   | ☐ c. Pancreas transplant<br>- How many times:<br>- Date(s) of surgery:   | ☐ c. Pancreas transplant<br>- How many times:<br>- Date(s) of surgery:   |
| ☐ d. Islet cell transplant<br>- How many times:<br>- Date(s) of surgery:   | ☐ d. Islet cell transplant<br>- How many times:<br>- Date(s) of surgery: | ☐ d. Islet cell transplant<br>- How many times:<br>- Date(s) of surgery: | ☐ d. Islet cell transplant<br>- How many times:<br>- Date(s) of surgery: |

| 12. Have any diabetic members of your family had a surgical amputation (resulting from diabetes)? <span style="float: right;">☐ Yes ☐ No ☐ Don't know</span> |   |   |   |
|--|---|---|---|
| <i>If so, please indicate the extremity removed and date of surgery.</i>   |   |   |   |
| First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:                               | First Name:<br>Year of Birth:                               | First Name:<br>Year of Birth:                               |
| 1. Please specify extremity:<br>_____<br>- Date of surgery:  | 1. Please specify extremity:<br>_____<br>- Date of surgery: | 1. Please specify extremity:<br>_____<br>- Date of surgery: | 1. Please specify extremity:<br>_____<br>- Date of surgery: |
| 2. Please specify extremity:<br>_____<br>- Date of surgery:  | 2. Please specify extremity:<br>_____<br>- Date of surgery: | 2. Please specify extremity:<br>_____<br>- Date of surgery: | 2. Please specify extremity:<br>_____<br>- Date of surgery: |
| 3. Please specify extremity:<br>_____<br>- Date of surgery:  | 3. Please specify extremity:<br>_____<br>- Date of surgery: | 3. Please specify extremity:<br>_____<br>- Date of surgery: | 3. Please specify extremity:<br>_____<br>- Date of surgery: |

13. Has a doctor ever told any members of your family that they have any of the following conditions?  Yes  No  Don't know  
*If so, please check whether this person has diabetes, all conditions that apply and age at diagnosis.*

|  |  |  |  |
|--|--|--|--|
| First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  | First Name:<br>Year of Birth:  |
| Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No   | Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No   | Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No   | Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| <input type="checkbox"/> a. High blood pressure (Hypertension)<br>- Age at dx:<br><input type="checkbox"/> b. Heart disease<br>- Age at dx:<br><input type="checkbox"/> c. Stroke<br>- Age at dx:<br><input type="checkbox"/> d. Hearing impairment<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx: | <input type="checkbox"/> a. High blood pressure (Hypertension)<br>- Age at dx:<br><input type="checkbox"/> b. Heart disease<br>- Age at dx:<br><input type="checkbox"/> c. Stroke<br>- Age at dx:<br><input type="checkbox"/> d. Hearing impairment<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx: | <input type="checkbox"/> a. High blood pressure (Hypertension)<br>- Age at dx:<br><input type="checkbox"/> b. Heart disease<br>- Age at dx:<br><input type="checkbox"/> c. Stroke<br>- Age at dx:<br><input type="checkbox"/> d. Hearing impairment<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx: | <input type="checkbox"/> a. High blood pressure (Hypertension)<br>- Age at dx:<br><input type="checkbox"/> b. Heart disease<br>- Age at dx:<br><input type="checkbox"/> c. Stroke<br>- Age at dx:<br><input type="checkbox"/> d. Hearing impairment<br>- Age at dx:<br><input type="checkbox"/> e. Other, please specify:<br>_____<br>- Age at dx: |

14. Do you have family members with diabetes, who have been insulin dependent for 20 years or more, without being diagnosed with any complications of diabetes?  Yes  No  Don't know  
*If so, please indicate the number of years that they have had diabetes without complications.*

|  |  |  |  |
|--|--|--|--|
| First Name:<br>Year of Birth:          | First Name:<br>Year of Birth:          | First Name:<br>Year of Birth:          | First Name:<br>Year of Birth:          |
| Number of years without complications: | Number of years without complications: | Number of years without complications: | Number of years without complications: |

15. Is your family involved in a research project, other than the HBDI Type 1 Diabetes program?  Yes  No  Don't know  
*If so, please indicate the title of the research project and the name and affiliation of the principle investigator.*

| Title of research project | Name of principal investigator | Affiliation (i.e., university or organization) |
|---------------------------|--------------------------------|--|
|                           |                                |  |
|                           |                                |  |
|                           |                                |  |

16. Do any members of your family take any medications not already mentioned?  Yes  No  Don't know

For example, are any members of your family taking Angiotensin Converting Enzyme (ACE) Inhibitors (i.e., benazepril [Lotensin], captopril [Capoten], enalapril [Vasotec], fosinopril [Monopril], lisinopril [Prinivil, Zestril], moexipril [Univasc], perindopril [Aceaon], quinapril [Accupril], ramipril [Altace] or trandolapril [Mavik]) to control high blood pressure, heart disease or kidney disease? *If so, please list medication, dosage, the year when the medication was first prescribed (if known) and the medical condition for which the medication was prescribed (i.e., high blood pressure). Please copy the name of your medication directly from your medicine vial.*

| First Name:<br>Year of Birth:                                      |                       |                                    | First Name:<br>Year of Birth:                                      |                       |                                    |
|--|-----------------------|------------------------------------|--|-----------------------|------------------------------------|
| Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |                                    | Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |                                    |
| Medication/Dose  | Year first prescribed | Condition that requires medication | Medication/Dose  | Year first prescribed | Condition that requires medication |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |

Question #15, additional space.

| First Name:<br>Year of Birth:                                      |                       |                                    | First Name:<br>Year of Birth:                                      |                       |                                    |
|--|-----------------------|------------------------------------|--|-----------------------|------------------------------------|
| Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |                                    | Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |                                    |
| Medication/Dose  | Year first prescribed | Condition that requires medication | Medication/Dose  | Year first prescribed | Condition that requires medication |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |
|  |                       |                                    |  |                       |                                    |

|   |
|---|
| 20. Please use this space for any <b>additional information</b> about your family that you want to share with HBDI and our researchers. |
|   |
|   |
|   |
|   |
|   |
|   |
|   |
|   |
|   |

|   |
|---|
| 21. Please provide contact information for your family and/or diabetes physician(s). If each member of your family has different physicians and/or specialists who treat complications of diabetes, please attach a list of physicians/specialists. |
| Name: _____ Clinic/Hospital: _____  |
| Specialty: <input type="checkbox"/> Family Physician <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Other, please specify: _____                  |
| Address: _____  |
|   |
| Phone: _____ Fax: _____   |
| Name: _____ Clinic/Hospital: _____  |
| Specialty: <input type="checkbox"/> Family Physician <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Cardiologist <input type="checkbox"/> Other, please specify: _____                  |
| Address: _____  |
|   |
| Phone: _____ Fax: _____   |

**HUMAN BIOLOGICAL DATA INTERCHANGE**  
A program of the National Disease Research Interchange  
Combined Effort of the  
Juvenile Diabetes Foundation International  
National Disease Research Interchange  
Coriell Medical Institute for Research

Upon receipt of this completed questionnaire, your family data will be coded for anonymity and included in the "Human Biological Data Interchange" database. Should a researcher request your family's participation in his/her research project, an HBDI coordinator will contact your family to discuss the details of your further participation.

HBDI's participation in this effort is limited to collecting the completed questionnaires and to serving as a coordinator between your family and the researcher. Further participation could include verification of data, additional questions, authorization for the release of your medical records or the donation of small amounts of blood.

\*\*\*\*

I understand that all my family data will be coded and anonymous and will be kept confidential. I agree that the data from my family may be used to help research projects aimed at the study of human disease, in particular Type 1 diabetes. My family and I agree to release the enclosed information to HBDI, who may release it to a researcher while keeping it coded, anonymous and confidential.

.....  
**Signature of Authorized Adult Family Representative**

.....  
**Printed Signature of Authorized Adult Family Representative**

.....  
**Date**

Thank you for your cooperation in completing this questionnaire. Please return to NDRI/HBDI, 1628 John F. Kennedy Boulevard, 8 Penn Center, 8th Floor, Philadelphia, Pennsylvania, USA 19103. For more information, please telephone the office of NDRI/HBDI at (800) 222-NDRI or (215) 557-7361.