

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

Section I: Contact Information

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

I understand that HBDI's participation in this effort is limited to collecting the completed questionnaires and to serving as a coordinator between my family and the researcher. My further participation may include verification of data, additional questions, request for authorization for the release of my medical records or the donation of small amounts of blood. Should a researcher request my family's participation in his/her research project, a HBDI coordinator will contact my family to discuss the details of further participation.

I agree to release the enclosed information to HBDI. Upon receipt of this completed questionnaire, my family data will be coded for anonymity and included in the "Human Biological Data Interchange" database. HBDI may release my anonymous data to researchers studying human disease, in particular Type 1 Diabetes.

Signature of Adult Family Representative

Date

Printed Signature of Adult Family Representative

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

Thank you for your cooperation in completing this questionnaire. Please return to NDRI/HBDI, 1628 JFK Blvd., 8 Penn Center, 8th Floor, Philadelphia, PA, 19103, USA. For more information, please call the office of NDRI/HBDI at (800) 345-HBDI (4234).

Section II. Family Profiles: Primary Family Profile

Full Name (First, Last)	Sex	Birth date (mm/dd/yy)	Alive? Yes or No	Age	Height ft. 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 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Father	M						<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
First Child							<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Second Child							<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Third Child							<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Fourth Child							<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Fifth Child							<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Sixth Child**							<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		

*Gestational diabetes is a type of diabetes that occurs only during pregnancy. **Please 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 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Grandfather	M				<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Uncle/Aunt					<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Uncle/Aunt					<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Uncle/Aunt					<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Uncle/Aunt					<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Cousin					<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		
Cousin**					<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Borderline <input type="checkbox"/> Gestational* <input type="checkbox"/> Not Diabetic	<input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Tablet/Pill <input type="checkbox"/> Diet Only <input type="checkbox"/> Other: _____		

*Gestational diabetes is a type of diabetes that occurs only during pregnancy. **Please attach additional pages if more space is needed.

Father's Family – Paternal

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

*Gestational diabetes is a type of diabetes that occurs only during pregnancy. **Please attach additional pages if more space is needed.

Section III. 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. **Questions 1-6 focus specifically on family members with diabetes.**

1. Eye Diseases: Do any **diabetic** members of your family have any of the complications listed below? If so, please list the family member(s) and check all that apply and **please include the age the condition was first diagnosed or treatment was performed.**

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
Complication	Age	Complication	Age	Complication	Age	Complication	Age
<input type="checkbox"/> No signs of retinopathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Non-proliferative (NPDR/background) retinopathy <input type="checkbox"/> Proliferative (PDR) retinopathy <input type="checkbox"/> Macular Edema <input type="checkbox"/> Partial blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Total blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Laser surgery Total #: _____ <input type="checkbox"/> Photocoagulation Total #: _____ <input type="checkbox"/> Vitrectomy Total #: _____		<input type="checkbox"/> No signs of retinopathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Non-proliferative (NPDR/background) retinopathy <input type="checkbox"/> Proliferative (PDR) retinopathy <input type="checkbox"/> Macular Edema <input type="checkbox"/> Partial blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Total blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Laser surgery Total #: _____ <input type="checkbox"/> Photocoagulation Total #: _____ <input type="checkbox"/> Vitrectomy Total #: _____		<input type="checkbox"/> No signs of retinopathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Non-proliferative (NPDR/background) retinopathy <input type="checkbox"/> Proliferative (PDR) retinopathy <input type="checkbox"/> Macular Edema <input type="checkbox"/> Partial blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Total blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Laser surgery Total #: _____ <input type="checkbox"/> Photocoagulation Total #: _____ <input type="checkbox"/> Vitrectomy Total #: _____		<input type="checkbox"/> No signs of retinopathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Non-proliferative (NPDR/background) retinopathy <input type="checkbox"/> Proliferative (PDR) retinopathy <input type="checkbox"/> Macular Edema <input type="checkbox"/> Partial blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Total blindness <input type="checkbox"/> Right eye <input type="checkbox"/> Left eye <input type="checkbox"/> Laser surgery Total #: _____ <input type="checkbox"/> Photocoagulation Total #: _____ <input type="checkbox"/> Vitrectomy Total #: _____	

2. Nerve Diseases: Do any **diabetic** members of your family have any of the complications listed below? If so, please list the family member(s), check all that apply and **please include the age the condition was first diagnosed.**

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
Complication	Age	Complication	Age	Complication	Age	Complication	Age
<input type="checkbox"/> No signs of neuropathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Neuropathy, type unknown <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Autonomic Neuropathy <input type="checkbox"/> Acute Sensory Neuropathy <input type="checkbox"/> Chronic Sensory Neuropathy <input type="checkbox"/> Other: <u>Pain</u> - burning, stinging, stabbing, 'pins & needles', etc. in the: <input type="checkbox"/> Legs/Feet <input type="checkbox"/> One side only <input type="checkbox"/> Both sides <input type="checkbox"/> Hands/arms <input type="checkbox"/> One side only <input type="checkbox"/> Both Sides <input type="checkbox"/> Other: <u>Pain developed:</u> <input type="checkbox"/> Quickly, within a few weeks <input type="checkbox"/> Slowly, over months or years		<input type="checkbox"/> No signs of neuropathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Neuropathy, type unknown <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Autonomic Neuropathy <input type="checkbox"/> Acute Sensory Neuropathy <input type="checkbox"/> Chronic Sensory Neuropathy <input type="checkbox"/> Other: <u>Pain</u> - burning, stinging, stabbing, 'pins & needles', etc. in the: <input type="checkbox"/> Legs/Feet <input type="checkbox"/> One side only <input type="checkbox"/> Both sides <input type="checkbox"/> Hands/arms <input type="checkbox"/> One side only <input type="checkbox"/> Both Sides <input type="checkbox"/> Other: <u>Pain developed:</u> <input type="checkbox"/> Quickly, within a few weeks <input type="checkbox"/> Slowly, over months or years		<input type="checkbox"/> No signs of neuropathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Neuropathy, type unknown <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Autonomic Neuropathy <input type="checkbox"/> Acute Sensory Neuropathy <input type="checkbox"/> Chronic Sensory Neuropathy <input type="checkbox"/> Other: <u>Pain</u> - burning, stinging, stabbing, 'pins & needles', etc. in the: <input type="checkbox"/> Legs/Feet <input type="checkbox"/> One side only <input type="checkbox"/> Both sides <input type="checkbox"/> Hands/arms <input type="checkbox"/> One side only <input type="checkbox"/> Both Sides <input type="checkbox"/> Other: <u>Pain developed:</u> <input type="checkbox"/> Quickly, within a few weeks <input type="checkbox"/> Slowly, over months or years		<input type="checkbox"/> No signs of neuropathy reported by patient <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Neuropathy, type unknown <input type="checkbox"/> Confirmed by doctor <input type="checkbox"/> Autonomic Neuropathy <input type="checkbox"/> Acute Sensory Neuropathy <input type="checkbox"/> Chronic Sensory Neuropathy <input type="checkbox"/> Other: <u>Pain</u> - burning, stinging, stabbing, 'pins & needles', etc. in the: <input type="checkbox"/> Legs/Feet <input type="checkbox"/> One side only <input type="checkbox"/> Both sides <input type="checkbox"/> Hands/arms <input type="checkbox"/> One side only <input type="checkbox"/> Both Sides <input type="checkbox"/> Other: <u>Pain developed:</u> <input type="checkbox"/> Quickly, within a few weeks <input type="checkbox"/> Slowly, over months or years	

3. Nerve Diseases, continued: Do any **diabetic** members of your family have any of the complications listed below? If so, please list the family member(s), check all that apply and **please include the age the symptom first appeared.**

Name:		Name:		Name:		Name:	
Birth date:		Birth date:		Birth date:		Birth date:	
Complication	Age	Complication	Age	Complication	Age	Complication	Age
<input type="checkbox"/> Elevated <u>resting</u> heart rate (over 100bpm) <input type="checkbox"/> Frequent dizziness upon standing <input type="checkbox"/> Often feeling too hot or too cold <input type="checkbox"/> Producing too much or too little sweat <input type="checkbox"/> Doctor's orders not to exercise strenuously <input type="checkbox"/> Gastroparesis (impaired stomach motility) <input type="checkbox"/> Intestinal problems (constipation, diarrhea, etc.) <input type="checkbox"/> Genito-Urinary tract problems (frequent bladder infections, incontinence, erectile dysfunction)		<input type="checkbox"/> Elevated <u>resting</u> heart rate (over 100bpm) <input type="checkbox"/> Frequent dizziness upon standing <input type="checkbox"/> Often feeling too hot or too cold <input type="checkbox"/> Producing too much or too little sweat <input type="checkbox"/> Doctor's orders not to exercise strenuously <input type="checkbox"/> Gastroparesis (impaired stomach motility) <input type="checkbox"/> Intestinal problems (constipation, diarrhea, etc.) <input type="checkbox"/> Genito-Urinary tract problems (frequent bladder infections, incontinence, erectile dysfunction)		<input type="checkbox"/> Elevated <u>resting</u> heart rate (over 100bpm) <input type="checkbox"/> Frequent dizziness upon standing <input type="checkbox"/> Often feeling too hot or too cold <input type="checkbox"/> Producing too much or too little sweat <input type="checkbox"/> Doctor's orders not to exercise strenuously <input type="checkbox"/> Gastroparesis (impaired stomach motility) <input type="checkbox"/> Intestinal problems (constipation, diarrhea, etc.) <input type="checkbox"/> Genito-Urinary tract problems (frequent bladder infections, incontinence, erectile dysfunction)		<input type="checkbox"/> Elevated <u>resting</u> heart rate (over 100bpm) <input type="checkbox"/> Frequent dizziness upon standing <input type="checkbox"/> Often feeling too hot or too cold <input type="checkbox"/> Producing too much or too little sweat <input type="checkbox"/> Doctor's orders not to exercise strenuously <input type="checkbox"/> Gastroparesis (impaired stomach motility) <input type="checkbox"/> Intestinal problems (constipation, diarrhea, etc.) <input type="checkbox"/> Genito-Urinary tract problems (frequent bladder infections, incontinence, erectile dysfunction)	
Has a doctor indicated that any of these symptoms are caused by your diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes (which?):		Has a doctor indicated that any of these symptoms are caused by your diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes (which?):		Has a doctor indicated that any of these symptoms are caused by your diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes (which?):		Has a doctor indicated that any of these symptoms are caused by your diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes (which?):	

4. Kidney Diseases: Do any **diabetic** members of your family have any of the complications listed below? If so, please list the family member(s), check all that apply and **include the age the condition was first diagnosed.**

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
Complication	Age	Complication	Age	Complication	Age	Complication	Age
<input type="checkbox"/> No protein in urine or other sign of kidney disease reported by patient <input type="checkbox"/> Confirmed by doctor		<input type="checkbox"/> No protein in urine or other sign of kidney disease reported by patient <input type="checkbox"/> Confirmed by doctor		<input type="checkbox"/> No protein in urine or other sign of kidney disease reported by patient <input type="checkbox"/> Confirmed by doctor		<input type="checkbox"/> No protein in urine or other sign of kidney disease reported by patient <input type="checkbox"/> Confirmed by doctor	
<input type="checkbox"/> Protein in urine <input type="checkbox"/> Microalbuminuria <input type="checkbox"/> Macroalbuminuria <input type="checkbox"/> Type unknown		<input type="checkbox"/> Protein in urine <input type="checkbox"/> Microalbuminuria <input type="checkbox"/> Macroalbuminuria <input type="checkbox"/> Type unknown		<input type="checkbox"/> Protein in urine <input type="checkbox"/> Microalbuminuria <input type="checkbox"/> Macroalbuminuria <input type="checkbox"/> Type unknown		<input type="checkbox"/> Protein in urine <input type="checkbox"/> Microalbuminuria <input type="checkbox"/> Macroalbuminuria <input type="checkbox"/> Type unknown	
<input type="checkbox"/> Nephropathy (Kidney Disease) <input type="checkbox"/> Confirmed by doctor		<input type="checkbox"/> Nephropathy (Kidney Disease) <input type="checkbox"/> Confirmed by doctor		<input type="checkbox"/> Nephropathy (Kidney Disease) <input type="checkbox"/> Confirmed by doctor		<input type="checkbox"/> Nephropathy (Kidney Disease) <input type="checkbox"/> Confirmed by doctor	
<input type="checkbox"/> End stage renal disease (ESRD)		<input type="checkbox"/> End stage renal disease (ESRD)		<input type="checkbox"/> End stage renal disease (ESRD)		<input type="checkbox"/> End stage renal disease (ESRD)	
<input type="checkbox"/> Kidney failure		<input type="checkbox"/> Kidney failure		<input type="checkbox"/> Kidney failure		<input type="checkbox"/> Kidney failure	
<input type="checkbox"/> Dialysis Duration: _____		<input type="checkbox"/> Dialysis Duration: _____		<input type="checkbox"/> Dialysis Duration: _____		<input type="checkbox"/> Dialysis Duration: _____	
<input type="checkbox"/> Kidney transplant <input type="checkbox"/> Multiple		<input type="checkbox"/> Kidney transplant <input type="checkbox"/> Multiple		<input type="checkbox"/> Kidney transplant <input type="checkbox"/> Multiple		<input type="checkbox"/> Kidney transplant <input type="checkbox"/> Multiple	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

5. Other Complications: Have any **diabetic** members of your family had a surgical amputation due to their diabetes? If so, please list the family member(s), indicate which extremities were removed and **include the age at which the surgery was performed.**

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
List surgeries below	Age	List surgeries below	Age	List surgeries below	Age	List surgeries below	Age
1. _____		1. _____		1. _____		1. _____	
2. _____		2. _____		2. _____		2. _____	
3. _____		3. _____		3. _____		3. _____	
4. _____		4. _____		4. _____		4. _____	

6a. No Complications: List all diabetic family members who do not suffer from any diabetic complications (complications can include eye disease, nerve disease, kidney disease, cardiovascular disease; see questions 2-6 for reference).

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
Years since the onset of Type 1 Diabetes:		Years since the onset of Type 1 Diabetes:		Years since the onset of Type 1 Diabetes:		Years since the onset of Type 1 Diabetes:	

6b. Delayed complication onset: Do you have any diabetic family member(s) who currently have complications, but did not develop those complications until at least 20 years after they started using insulin? Please list below.

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
When did complications first develop? (age or year of onset):		When did complications first develop? (age or year of onset):		When did complications first develop? (age or year of onset):		When did complications first develop? (age or year of onset):	

The following questions apply to all members of your family, not just those with diabetes.

7. Autoimmune Diseases: Do any members of your family have any of the diseases listed below? If so, please list the family member(s), check all the disease(s) that apply and please include the age the disease was first diagnosed.							
Name:		Name:		Name:		Name:	
Birth date:		Birth date:		Birth date:		Birth date:	
Disease	Age	Disease	Age	Disease	Age	Disease	Age
<input type="checkbox"/> Addison's Disease <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Congenital Rubella <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Graves' Disease (hyperthyroid) <input type="checkbox"/> Hashimoto's (hypothyroid) <input type="checkbox"/> Lupus <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Other, please specify:		<input type="checkbox"/> Addison's Disease <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Congenital Rubella <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Graves' Disease (hyperthyroid) <input type="checkbox"/> Hashimoto's (hypothyroid) <input type="checkbox"/> Lupus <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Other, please specify:		<input type="checkbox"/> Addison's Disease <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Congenital Rubella <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Graves' Disease (hyperthyroid) <input type="checkbox"/> Hashimoto's (hypothyroid) <input type="checkbox"/> Lupus <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Other, please specify:		<input type="checkbox"/> Addison's Disease <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Congenital Rubella <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Graves' Disease (hyperthyroid) <input type="checkbox"/> Hashimoto's (hypothyroid) <input type="checkbox"/> Lupus <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Other, please specify:	
For each disease listed above, please indicate name of medications taken for that disease (if known).							
Medication(s):		Medication(s):		Medication(s):		Medication(s):	

8. Other Conditions: Do **any** members of your family have any of the conditions listed below? If so, please list the family member(s), check all that apply and **include the age or year the condition was first diagnosed**.

Name:		Name:		Name:		Name:	
Birthdate:		Birthdate:		Birthdate:		Birthdate:	
Condition	Age	Condition	Age	Condition	Age	Condition	Age
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> High blood pressure		<input type="checkbox"/> High blood pressure		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Heart disease		<input type="checkbox"/> Heart disease		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Stroke		<input type="checkbox"/> Stroke		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Hearing impairment		<input type="checkbox"/> Hearing impairment		<input type="checkbox"/> Hearing impairment		<input type="checkbox"/> Hearing impairment	
<input type="checkbox"/> Other, please specify:		<input type="checkbox"/> Other, please specify:		<input type="checkbox"/> Other, please specify:		<input type="checkbox"/> Other, please specify:	

9. Medications: Do any family members take medications not already mentioned, including medications for high blood pressure, heart disease or kidney disease? If so, please list the medication, condition treated and **include the age it was first prescribed, if known**.

Name:			Name:		
Birthdate:			Birthdate:		
List medications and dose below:	Age	Disease treated	List medications and dose below:	Age	Disease treated
1. _____		1. _____	1. _____		1. _____
2. _____		2. _____	2. _____		2. _____
3. _____		3. _____	3. _____		3. _____
4. _____		4. _____	4. _____		4. _____
5. _____		5. _____	5. _____		5. _____

9. Medications, continued from previous page:

Name:			Name:		
Birthdate:			Birthdate:		
List medications and dose below:	Age	Disease treated	List medications and dose below:	Age	Disease treated
1. _____		1. _____	1. _____		1. _____
2. _____		2. _____	2. _____		2. _____
3. _____		3. _____	3. _____		3. _____
4. _____		4. _____	4. _____		4. _____
5. _____		5. _____	5. _____		5. _____

10. Additional info: Please use this space for any **additional information** about your family that you want to share with HBDI and our researchers.
