INHERITED KIDNEY DISEASE HEALTH SURVEY

Please fill out the following survey as completely as possible.
A separate form needs to be completed for each family member.

Part 1: CONTACT & FAMILY INFORMATION

1. Name:_____ Date:_____

2. Date of Birth:_____ Sex: M____ F____ Race:_____ Ethnicity:_____

3. Address:_____

4. Home Phone:_____ Cell Phone:_____ Work Phone:_____

5. Email address:_____

6. What is your doctor's name? _____ Phone:_____

Is it OK if we contact your doctor and ask about your records and health? Yes_____ No_____

7. Father's name: _____ Mother's Name:_____

Your spouse's name:_____

8. Please list the following information for each for your children:

a. Name:_____ Other parent's name:_____

Sex: M____ F_____ Date of birth:_____ Phone:_____

b. Name:_____ Other parent's name:_____

Sex: M____ F_____ Date of birth:_____ Phone:_____

c. Name:_____ Other parent's name:_____

Sex: M____ F_____ Date of birth:_____ Phone:_____

d. Name:_____ Other parent's name:_____

Sex: M____ F_____ Date of birth:_____ Phone:_____

e. Name:_____ Other parent's name:_____

Sex: M____ F_____ Date of birth:_____ Phone:_____

f. Name:_____ Other parent's name:_____

Sex: M____ F_____ Date of birth:_____ Phone:_____

Part 2: CURRENT HEALTH

1. What is your current:

Age	Weight	Height	Blood pressure
	lbs/kg	in/cm	

2. Do you currently smoke cigarettes? Yes_____ No_____

   a. If yes, how many cigarettes/day?

1-10	11-20	21-30	31-40	41+

3. What is your usual walking pace outdoors? (check which applies to you)

Unable to walk	Easy, Casual (less than 2 mph)	Normal, average (2-2.9 mph)	Brisk pace (3-3.9 mph)	Very Brisk/Striding (4 mph +)

4. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities? (check which applies to you)

Activity	0 min	1-20 min	20-60 min	1-1.5 hrs	2-3 hrs	4-5 hrs	6-8 hrs	8+ hrs
Walking for exercise or errands								
Running or jogging								
Bicycling, swimming, aerobic exercise								

5. When do you go to bed? (write the time, circle am or pm)

Workdays	Weekends
☐☐ am/pm	☐☐ am/pm

6. When you wake up? (write the time, circle am or pm)

Workdays	Weekends
☐☐ am/pm	☐☐ am/pm

7. When was your last serum creatinine taken, and what was it?

Date of lab (mm/dd/yyyy)	Serum Creatinine

8. Are you on dialysis? Yes_____ No_____ Have you had a kidney transplant? Yes_____ No_____

   a. If yes, when did you 1st begin dialysis or have your 1st transplant? _____

Part 3: HEALTH HISTORY

*For questions that ask "when", you can give your age or the year when it began or happened.

1. Have you ever smoked cigarettes on a regular basis? Yes_____ No_____
    a. If yes, when did you start? _____
    b. If yes, how many cigarettes/day?

1-10	11-20	21-30	31-40	41+

    c. When did you quit (if applicable)? _____
2. Do you have high blood pressure? Yes_____ No_____
    a. If yes, when was it diagnosed? _____
    b. How was it treated? _____
3. Did you have trouble with bedwetting at night after the age of four? Yes_____ No_____
    a. If yes, when did you stop having problems with bedwetting? _____
4. Have you ever had a gout attack? Yes_____ No_____
    a. If yes, when was your 1st attack? _____
5. Have you taken a medication called Allopurinol or Colchicine (circle which one you took)? Yes_____ No_____
    a. If yes, when did you start regularly taking the medication? _____
6. Have you ever been told you have problems with your kidney function? Yes_____ No_____
    a. If yes, when was it? _____
7. Have you ever had a CAT scan, MRI, or ultrasound of your kidneys or abdomen? Yes_____ No_____
    a. If yes, when was it? _____
    b. If yes, where was it performed/name of group? _____
8. Have you ever had a biopsy? A biopsy is where a small piece of tissue is removed to diagnose a disease like cancer, stomach ulcer, colon polyp, kidney disease, etc… Yes_____ No_____
    a. If yes, what type of biopsy was it? _____
    b. If yes, when did you have the biopsy? _____
    c. If yes, where was the biopsy performed/name of group? _____
9. Have you ever had cancer of any type? Yes_____ No_____
    a. If yes, what type of cancer? _____
10. How many times have you or your significant other been pregnant? _____
11. How many miscarriages have you or your significant other had? _____

Part 4: MEDICATIONS

If you have NOT had a transplant and are NOT on dialysis:
Please list the medications you currently take and/or any medications you have been on for a long time.

Name of medication	Dose	How often did you take it?	Age or Year started	Age or year stopped

Part 5: FOOD INTAKE

1. Place a check in the column for the items you eat: Daily, Often (3-6 times/week), Sometimes (1-2 times/week) or Rarely/Never
2. Circle Regular or Light, Regular or Decaf, etc… if specified

Foods	Daily	Often	Some-times	Rarely/ Never	Foods	Daily	Often	Some-times	Rarely/ Never
MILK PRODUCTS					**MEAT/PROTEIN** (con't)				
Whole Milk					Cold Cuts				
2% Milk					Hot Dogs				
1% or Skim Milk					Liver/Organ meats				
Chocolate Milk					Cheese: Regu or Light				
Buttermilk					Cottage Cheese				
Ice Cream: Reg or Lig					Eggs				
Yogurt: Regu or Froze					Egg Substitute				
VEGETABLES					Peanut Butter				
Canned					Soy/Tofu				
Fresh					**FATS**				
Frozen					Butter				
Salads: lettuce/spinach					Margarine: Reg or Lig				
FRUITS					Cream				
Canned					Salad Drsg: Regular or Light				
Fresh					Bacon				
Frozen					Oil Type:				
Juice					Nuts				
BREADS/STARCHES					**BEVERAGES**				
Bread: wheat white					Tea: Reg or Decaf				
Muffins					Coffee: Reg or Decaf				
Biscuits					Soft Drinks				
Crackers					Diet Soft Drinks				
Dry Cereal					Water				
Cooked Cereal					Sports Drinks				
Potatoes					Beer: Reg or Light				
Rice: white brown					Wine				
Spaghetti/Pasta/Noodles					Mixed Drinks				
Dried Beans					**MISCELLANEOUS**				
Corn					Sugar Substitutes				
Peas					Sugar				
MEAT/PROTEIN					Candy				
Beef					Desserts				
Pork					Italian Foods				
Fish					Mexican Foods				
Poultry					Asian Foods				
Shellfish					Fast Foods				

OTHER FOODS YOU FREQUENTLY EAT THAT ARE NOT LISTED:

Part 6: VITAMINS, SUPPLEMENTS & OVER THE COUNTER MEDICATIONS

1. OVER THE PAST YEAR, have you taken or currently take any of the following?

   Check Yes or No. If specified, please write the brand that you use.

Name/Type	Yes	No
Multivitamin Brand:		
Vitamin A		
Potassium		
Vitamin C		
Vitamin B6		
Vitamin E		
Calcium		
Selenium		
Vitamin D		
Zinc		
Dietary Fiber Brand:		
Cod Liver Oil		
Fish Oil		
Flax Seed Oil		
Beta Carotene		
Melatonin		
Vitamin B12		
Chromium		
Vitamin Water		
Coenzyme Q10		
Niacin		
Folic Acid		
B-Complex		
Ginkgo Biloba		
Lycoprene		
Glucosamine/Chondroitin		
Iron		
Magnesium		
Acetaminophen (e.g., Tylenol)		
“Baby” or low dose aspirin		
Aspirin or aspirin-containing products		
Ibuprofen (e.g., Advil, Motrin)		
Other anti-inflammatory analgesic (e.g., Aleve, Ketoprofen)		
Not listed:		
Not listed:		
Not listed:		

Part 7: Health History FOR WOMEN ONLY

*For questions that ask "when", you can give your age or the year when it began or happened.

1. How old were you when you had your 1st menstrual cycle/period? _____

2. Have you ever taken birth control pills? Yes_____ No_____

    a. If yes, when did you start? _____

    b. How long did you take them? _____

3. If you have children, did you breastfeed your children? Yes_____ No_____

    a. If yes, how long was each child breastfed?

Child 1	Child 2	Child 3	Child 4	Child 5	Child 6

4. Have you gone through menopause? Yes_____ No_____

    a. If yes, when did it happen? _____

    b. Did you have Hormone Replacement Therapy? Yes_____ No_____

5. Have you ever had a mammogram? Yes_____ No_____

    a. If yes, have you ever received a call back about it? Yes_____ No_____

    b. If yes, what was the reason for call back?

    _____cyst/lump ____calcification ____ "dense breast" _____other

    c. Did you need to have a biopsy/lumpectomy? Yes_____ No_____

    d. If yes, what were the results of further testing? _____