

BRIEF QUESTIONNAIRE (for patients and family members)

Name (First, Last): _____ Maiden Name: _____
 Mother (First, Last): _____ Maiden Name: _____
 Father (First, Last): _____ Are your parents related? No Yes
 Date of Birth: _____ Nationality: _____ Sex: Male Female
 Ethnicity: White Black Hispanic Asian Other Weight: _____ Height: _____
 Does anyone else have kidney problems in your family? No Yes, who? _____
 What is your kidney disease? _____ Diagnosis date: _____
 How was the diagnosis made? Kidney Biopsy Skin Biopsy Clinical/Other
 Have you received a kidney transplant? No Yes, date: _____
 Have you ever been treated with dialysis? No Yes, date: _____
 Have you had your tonsils removed? No Yes, date: _____
 Have you had any of the following: Blood in the urine or dark/tea-colored urine?
 High blood pressure or hypertension?
 High sugars or diabetes?
 Purple skin rash?
 Do you take any of the following: Blood pressure medications?
 Steroids?
 Other medications that suppress your immune system:

CLINICAL DATA FORM (for physicians)

Blood Pressure _____ Date: _____	Diagnosis _____
Recruitment Cr _____ Date: _____	Kidney Biopsy _____ Date: _____
Diagnosis Cr _____ Date: _____	Antihypertensives: <input type="checkbox"/> ACEI or ARB <input type="checkbox"/> Other:
Urine Protein _____ Date: _____	Immunosuppressants: <input type="checkbox"/> MMF <input type="checkbox"/> Steroids <input type="checkbox"/> CNI (CyA, Tac) <input type="checkbox"/> Cytoxin <input type="checkbox"/> Other:
Urine Cr _____ Date: _____	
24hr Urine Pr _____ Date: _____	
Dip Protein: <input type="checkbox"/> None <input type="checkbox"/> Trace <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+/more Date: _____	
Dip Heme: <input type="checkbox"/> None <input type="checkbox"/> Trace <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+/more Date: _____	