



Participant ID:

Participant Initials:

Site:

Visit Number:

CRF Date:

RC ID:

BIOLOGICAL PARENT MEDICAL HISTORY

Display Name- 6 Months: Biological Parent Medical History

Past Medical History of Biological Mother (Record all past and current diagnoses/conditions)

- Heart disease Yes No Don't Know
- Stroke or vascular disease Yes No Don't Know
- Memory problems or dementia Yes No Don't Know
- Cancer Yes No Don't Know

Note: If 'no' or 'don't know', skip to 'high blood cholesterol' question.

Please specify cancer type: (specify site/type):

- High blood cholesterol..... Yes No Don't Know
- Hypertension (high blood pressure)..... Yes No Don't Know
- Diabetes (high blood sugar)..... Yes No Don't Know
- Asthma Yes No Don't Know
- Chronic Obstructive Pulmonary Disease (COPD) Yes No Don't Know
- Chronic Bronchitis Yes No Don't Know

Past Medical History of Biological Father (Record all past and current diagnoses/conditions)

- Heart disease Yes No Don't Know
- Stroke or vascular disease..... Yes No Don't Know
- Memory problems or dementia Yes No Don't Know
- Cancer Yes No Don't Know

Note: If 'no' or 'don't know', skip to 'high blood cholesterol' question.

Please specify cancer type: (specify site/type):

- High blood cholesterol..... Yes No Don't Know
- Hypertension (high blood pressure)..... Yes No Don't Know
- Diabetes (high blood sugar)..... Yes No Don't Know
- Asthma Yes No Don't Know
- Chronic Obstructive Pulmonary Disease (COPD) Yes No Don't Know
- Chronic Bronchitis Yes No Don't Know

Thank You for Completing this Questionnaire!

For Research Coordinator use only: CRF was: Self-administered Interviewer-administered