DEMOGRAPHIC FORM

ID NUMBER: ☐ ☐ ☐ ☐ ☐ ☐ ☐ | FORM CODE: **DEM** VERSION: **A** 03/26/08 | Visit Number ☐0☐ ☐1☐ | SEQ # ☐0☐ ☐0☐

Instructions: *This form is to be completed on all patients in the Registry after informed consent is received. Information is obtained through patient interview or from patient chart or electronic medical record review.*

1. Patient's date of birth (mm/dd/yyyy)? .... ☐☐/☐☐/☐☐☐☐

2. Patient's gender? .... M   F

3. Is the patient of Hispanic ethnicity (origin)? .... Y   N   U   R

4. Which of the following best describes the patient's race?
(Answer each. *Y, N, U, R indicates Yes, No, Unknown, Refused.*)

   a. White... Y   N   U   R

   b. Black or African-American .... Y   N   U   R

   c. Asian .... Y   N   U   R

   d. Native Hawaiian or Other Pacific Islander .... Y   N   U   R

   e. American Indian or Alaska Native.. Y   N   U   R

   f. Other .... Y   N   U   R

      1. If other, please specify: _____

5. Patient's country of origin (birth)? *(Circle one)*
(A=USA, C=Canada, M=Mexico, O=Other, U=Uknown, R=Refused) .... A   C   M   O   U   R

   a. If other, please specify: _____

6. What are the patient's physical measurements?

   a. Weight.. ☐☐☐.☐

   b. Weight units *(circle one)*:

      Kilograms .... K

      Pounds .... P

   c. Height .... ☐☐☐.☐

   d. Height Units *(circle one)*:

      Centimeters.. C

      Inches... I

7. Is the patient currently receiving public assistance (include WIC,

   food stamps, SSI)? *(Circle one.)* .... Y   N   U   R

8. What primary medical insurance does the patient currently have? *(circle one)*

Commercial insurance C

Tricare (formerly CHAMPUS) .... T

Medicaid or other state-promoted program .... M

Medicare .... R

No insurance .... N

Declined .... D

Unknown .... U

Other .... O

   a. If other, please specify: _____

9. What is the highest level of education completed by the patient? *(circle one)*

Less than high school .... A

Some high school .... B

High School diploma/GED C

Some college or 2-year degree/certificate .... D

College graduate... E

Post-graduate .... F

Refused... G

Unknown .... H

10. Exam / interview / medical records date (mm/dd/yyyy):................................ ☐☐/☐☐/☐☐☐☐

11. Source of Data:
   a. Participant interview .... Y   N
   b. Participant exam.. Y   N
   c. Medical records review/abstraction .... Y   N

12. Form date (mm/dd/yyyy): .... ☐☐/☐☐/☐☐☐☐

13. Interviewer's / recorder's initials:... ☐☐☐