S02r1 Demographic and Phenotypic Information

Patient's Identification Number _____

Visit Date: _____

Correction:
- ☐ Yes
- ☐ No

1. Is the patient fluent in English?
- ☐ Yes
- ☐ No

2. Is English the patient's first language?
- ☐ Yes
- ☐ No

2A. If No, what is the patient's first language? _____

3. What is the patient's ethnic group (choose one)?
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

4. What is the patient's race (choose one)?
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown

4A. If Other, specify: _____

5. What is the patient's national/geographic origin (choose one)?
- ☐ UK
- ☐ France
- ☐ Canada
- ☐ Africa
- ☐ Caribbean
- ☐ USA
- ☐ Other
- ☐ Unknown

5A. If Other, specify: _____

6. What is the patient's biological mother's ethnic group (choose one)?
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

7. What is the patient's biological mother's race (choose one)?
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown

7A. If Other, specify: _____

8. What is the patient's biological mother's national/geographical origin (choose one)?
- ☐ UK
- ☐ France
- ☐ Canada
- ☐ Africa
- ☐ Caribbean
- ☐ USA
- ☐ Other
- ☐ Unknown

8A. If Other, specify: _____

9. What is the patient's biological father's ethnic group (choose one)?
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

10. What is the patient's biological father's race (choose one)?
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown

10A. If Other, specify: _____

11. What is the patient's biological father's national/geographical origin (choose one)?
- ☐ UK
- ☐ France
- ☐ Canada
- ☐ Africa
- ☐ Caribbean
- ☐ USA
- ☐ Other
- ☐ Unknown

11A. If Other, specify: _____

12A. Patient's current grade (xx): _____

12B. Patient's most recently completed grade (xx): _____

12C. Has patient ever repeated a grade?
- ☐ Yes
- ☐ No

12C-1A. If Yes, grade repeated (xx) _____

12C-1B. Number of times grade repeated (xx): _____

12C-2A. If Yes, grade repeated (xx): _____

12C-2B. Number of times grade repeated (xx): _____

12C-3A. If Yes, grade repeated (xx): _____

12C-3B. Number of times grade repeated (xx): _____

12C-4A. If Yes, grade repeated (xx): _____

12C-4B. Number of times grade repeated (xx): _____

12D. Is the patient in a classroom setting requiring special attention?
- ☐ Yes
- ☐ No

12E. Does the patient have an Individual Educational Plan (IEP) in place?
- ☐ Yes
- ☐ No

12E-1. If Yes, what grade was it implemented? (xx) _____

12F. Does the patient have a 504 plan in place (USA sites only)?
- ☐ Yes
- ☐ No

12F-1. If Yes, what grade was it implemented? _____

13. Head of Household: What is the highest grade or level of school that you have completed or the highest degree that you have received?

- ☐ 1st
- ☐ 2nd
- ☐ 3rd
- ☐ 4th
- ☐ 5th
- ☐ 6th
- ☐ 7th
- ☐ 8th
- ☐ 9th
- ☐ 10th
- ☐ 11th
- ☐ 12th, no diploma
- ☐ High school graduate
- ☐ GED or equivalent
- ☐ Some college, no degree
- ☐ Associate degree, occupational, technical degree
- ☐ Associate degree (academic program)
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional/doctoral degree (MD, JD, DDS, DVM, PhD)
- ☐ Refused to answer
- ☐ Unknown

14. Marital status of primary caregiver:

- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Never married
- ☐ Living with partner
- ☐ Refused to answer
- ☐ Unknown

15. Relationship of primary caregiver to patient:

- ☐ Mother
- ☐ Father
- ☐ Niece or nephew
- ☐ Aunt or uncle
- ☐ First cousin
- ☐ Second cousin
- ☐ Unknown cousin
- ☐ Grandparent
- ☐ Great grandparent
- ☐ Great great grandparent
- ☐ Great aunt or great uncle
- ☐ Great great aunt or great great uncle
- ☐ Foster parent
- ☐ Other

15A. If Other, specify: _____

16. Yearly family income ($USD):

- ☐ < $10,000
- ☐ $10,000 to $19,999
- ☐ $20,000 to $29,999
- ☐ $30,000 to $39,999
- ☐ $40,000 to $49,999
- ☐ $50,000 to $59,999
- ☐ $60,000 to $69,999
- ☐ $70,000 to $79,999
- ☐ $80,000 to $89,999
- ☐ $90,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ >= $150,000
- ☐ Refused to answer
- ☐ Unknown

17. Number of people in home age 17 or older (xx): _____

18. Number of people in home age 16 or younger (xx): _____

19. Type of health insurance (answer each item):

19A. Government Health Services (non-USA sites)
- ☐ Yes
- ☐ No

19B. Medicaid
- ☐ Yes
- ☐ No

19C. Private
- ☐ Yes
- ☐ No

19D. None
- ☐ Yes
- ☐ No

20. Did a doctor ever say that the patient had asthma?
- ☐ Yes
- ☐ No

20A. If Yes, does the patient still have asthma?
- ☐ Yes
- ☐ No

21. Has either or both of (patient's) biological parents ever been told by a doctor that he/she has asthma or hay fever at any age?
- ☐ Yes
- ☐ No

21A. If Yes, choose one:
- ☐ Mother
- ☐ Father
- ☐ Unknown
- ☐ Both parents

22. Does either the patient or the primary caretaker identify anyone living in the home who smokes or smoked tobacco products in the last 3 years, either inside or outside the home?
- ☐ Yes
- ☐ No

23. Handedness
- ☐ Right
- ☐ Left

Headaches

24. Does your child have recurring headaches (choose one)? If Yes, complete Items 25-32. If No, skip to Item 33.
- ☐ No
- ☐ Yes (< 1 per month)
- ☐ Yes (1-4 per month)
- ☐ Yes (>= 1 per week)

25. How long have headaches been present (choose one)?
- ☐ < 6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ > 2 years

26. Where is the headache typically located (choose one)?
- ☐ Bifrontal or bitemporal
- ☐ Right hemicranial
- ☐ Left hemicranial
- ☐ Vertex
- ☐ Occipital
- ☐ Non-localized, diffuse

27. Duration of typical headache (choose one)?
- ☐ < 10 minutes
- ☐ 10-59 minutes
- ☐ 1-6 hours
- ☐ > 6 hours

28. When does the headache most often occur (choose one)?
- ☐ During daytime at school
- ☐ During afternoon/evening after coming home from school
- ☐ Late evening, bed time
- ☐ No particular time

29. Severity of typical headache (choose one):
- ☐ No interruption of normal life activities
- ☐ Some disruption of normal life activities, but no need to go to bed
- ☐ Complete disruption of normal life activities, needs to go to bed
- ☐ Prevents sleep or requires patient to be examined by physician
- ☐ Awakens patient from sleep

30A. Other symptoms associated with some or most headaches: nausea or vomiting
- ☐ Yes
- ☐ No

30B. Other symptoms associated with some or most headaches: excessive sensitivity to light or sound
- ☐ Yes
- ☐ No

30C. Other symptoms associated with some or most headaches: fatigue, malaise
- ☐ Yes
- ☐ No

30D. Other symptoms associated with some or most headaches: sleep apnea
- ☐ Yes
- ☐ No

30E. Other symptoms associated with some or most headaches: excessive daytime sleep
- ☐ Yes
- ☐ No

30F. Other symptoms associated with some or most headaches: visual symptoms
- ☐ Yes
- ☐ No

30F-1. If Yes, specify: _____

30G. Other symptoms associated with some or most headaches: other
- ☐ Yes
- ☐ No

30G-1. If Other, specify: _____

31. Is medication taken for most headaches?
- ☐ No
- ☐ Yes, abortive or rescue medication
- ☐ Yes, daily preventative medication

31A. If Yes to abortive or rescue medication, specify: _____

31A. If Yes to preventative medication, specify: _____

31A-1. If Yes to rescue or abortive medication, how effective is it?
- ☐ Partial improvement most occasions
- ☐ Complete remission most occasions
- ☐ Little or no improvement most occasions

32. Are there other family members with a history of recurrent headaches?
- ☐ Yes
- ☐ No
- ☐ Don't know

32A. If Yes, have they been given the diagnosis of migraines?
- ☐ Yes
- ☐ No
- ☐ Don't know

33. Has the patient ever experienced a seizure?
- ☐ Yes
- ☐ No
- ☐ Don't know

33A. If Yes, was the seizure associated with fever?
- ☐ Yes
- ☐ No
- ☐ Don't know

33B. If Yes, was the seizure associated with pain crisis?
- ☐ Yes
- ☐ No
- ☐ Don't know

34. Have other family members had seizures?
- ☐ Yes
- ☐ No
- ☐ Don't know

34A. If Yes, relationship to patient: _____

35. Has the patient ever had a diagnosis of a silent stroke?
- ☐ Yes
- ☐ No
- ☐ Don't know

35A. If Yes, reason for MRI:
- ☐ Routine care or surveillance
- ☐ Suspected stroke
- ☐ Recurrent headaches
- ☐ Headache
- ☐ Seizure
- ☐ Abnormal TCD

35B. If Yes, year of diagnosis of silent stroke (yyyy): _____

36A. Do you know the patient's biological mother's date of birth?
- ☐ Yes
- ☐ No

36A-1. If Yes, enter patient's biological mother's date of birth (yyyy/mm/dd)? _____

36B. Does the patient's biological mother have sickle cell disease?
- ☐ Yes
- ☐ No
- ☐ Don't know

36B-1. If Yes, what type?
- ☐ Hgb SS
- ☐ HgB S(beta0) Thalassemia
- ☐ HgB SC
- ☐ Other
- ☐ Unknown

36C. Is the patient's biological mother alive?
- ☐ Yes
- ☐ No
- ☐ Don't know

36C-1. If No, year of death (yyyy): _____

36C-2. If No, cause of death: _____

37A. Do you know the patient's biological father's date of birth?
- ☐ Yes
- ☐ No

37A-1. If Yes, enter patient's biological father's date of birth? (yyyy/mm/dd) _____

37B. Does the patient's biological father have sickle cell disease?
- ☐ Yes
- ☐ No
- ☐ Don't know

37B-1. If Yes, what type?
- ☐ Hgb SS
- ☐ HgB S(beta0) Thalassemia
- ☐ HgB SC
- ☐ Other
- ☐ Unknown

37C. Is the patient's biological father alive?
- ☐ Yes
- ☐ No
- ☐ Don't know

37C-1. If No, year of death (yyyy): _____

37C-2. If No, cause of death: _____

38. Does the patient have siblings? If No or Unknown, skip to Item 45.
- ☐ Yes
- ☐ No
- ☐ Unknown

38A. If Yes, how many siblings (xx)? _____

Enter information for up to 6 siblings on this form (Form 2, Items 39-44). If you need to enter additional siblings, use Form 38.

39A. Do you know the sibling's date of birth?
- ☐ Yes
- ☐ No

39A-1. If Yes, enter sibling's date of birth (yyyy/mm/dd): _____

39B. Gender:
- ☐ Male
- ☐ Female

39C. Hemoglobin genotype:
- ☐ SS
- ☐ SC
- ☐ S beta thalassemia zero
- ☐ Sickle cell trait
- ☐ AA normal
- ☐ Unknown

39D. Asthma:
- ☐ Yes
- ☐ No
- ☐ Unknown

39E. Same biological mother:
- ☐ Yes
- ☐ No
- ☐ Unknown

39F. Same biological father:
- ☐ Yes
- ☐ No
- ☐ Unknown

40A. Do you know the sibling's date of birth?
- ☐ Yes
- ☐ No

40A-1. If Yes, enter sibling's date of birth (yyyy/mm/dd): _____

40B. Gender:
- ☐ Male
- ☐ Female

40C. Hemoglobin genotype:
- ☐ SS
- ☐ SC
- ☐ S beta thalassemia zero
- ☐ Sickle cell trait
- ☐ AA normal
- ☐ Unknown

40D. Asthma:
- ☐ Yes
- ☐ No
- ☐ Unknown

40E. Same biological mother:
- ☐ Yes
- ☐ No
- ☐ Unknown

40F. Same biological father:
- ☐ Yes
- ☐ No
- ☐ Unknown

41A. Do you know the sibling's date of birth?
- ☐ Yes
- ☐ No

41A-1. If Yes, enter sibling's date of birth (yyyy/mm/dd): _____

41B. Gender:
- ☐ Male
- ☐ Female

41C. Hemoglobin genotype:
- ☐ SS
- ☐ SC
- ☐ S beta thalassemia zero
- ☐ Sickle cell trait
- ☐ AA normal
- ☐ Unknown

41D. Asthma:
- ☐ Yes
- ☐ No
- ☐ Unknown

41E. Same biological mother:
- ☐ Yes
- ☐ No
- ☐ Unknown

41F. Same biological father:
- ☐ Yes
- ☐ No
- ☐ Unknown

42A. Do you know the sibling's date of birth?
- ☐ Yes
- ☐ No

42A-1. If Yes, enter sibling's date of birth (yyyy/mm/dd): _____

42B. Gender:
- ☐ Male
- ☐ Female

42C. Hemoglobin genotype:
- ☐ SS
- ☐ SC
- ☐ S beta thalassemia zero
- ☐ Sickle cell trait
- ☐ AA normal
- ☐ Unknown

42D. Asthma:
- ☐ Yes
- ☐ No
- ☐ Unknown

42E. Same biological mother:
- ☐ Yes
- ☐ No
- ☐ Unknown

42F. Same biological father:
- ☐ Yes
- ☐ No
- ☐ Unknown

43A. Do you know the sibling's date of birth?
- ☐ Yes
- ☐ No

43A-1. If Yes, enter sibling's date of birth (yyyy/dd/mm): _____

43B. Gender:
- ☐ Male
- ☐ Female

43C. Hemoglobin genotype:
- ☐ SS
- ☐ SC
- ☐ S beta thalassemia zero
- ☐ Sickle cell trait
- ☐ AA normal
- ☐ Unknown

43D. Asthma:
- ☐ Yes
- ☐ No
- ☐ Unknown

43E. Same biological mother:
- ☐ Yes
- ☐ No
- ☐ Unknown

43F. Same biological father:
- ☐ Yes
- ☐ No
- ☐ Unknown

44A. Do you know the sibling's date of birth?
- ☐ Yes
- ☐ No

44A-1. If Yes, enter sibling's date of birth (yyyy/mm/dd): _____

44B. Gender:
- ☐ Male
- ☐ Female

44C. Hemoglobin genotype:
- ☐ SS
- ☐ SC
- ☐ S beta thalassemia zero
- ☐ Sickle cell trait
- ☐ AA normal
- ☐ Unknown

44D. Asthma:
- ☐ Yes
- ☐ No
- ☐ Unknown

44F. Same biological mother:
- ☐ Yes
- ☐ No
- ☐ Unknown

44F. Same biological father:
- ☐ Yes
- ☐ No
- ☐ Unknown

45. Please mark the patient's sickle hemoglobinopathy diagnosis:
- ☐ Hgb SS
- ☐ Hgb S beta thalassemia zero

46A. Most recent quantitative hemoglobin - date (yyyy/mm/dd): _____

46B. Most recent quantitative hemoglobin - unit:
- ☐ Conventional: g/dl
- ☐ SI: mmol/L

46B-1. Most recent quantitative hemoglobin - value (xx.x g/dl): _____

46B-1. Most recent quantitative hemoglobin - value (x.xx mol/L): _____

47A. Percent of Type S hemoglobin (xx %): _____

47B. Percent of Type F hemoglobin (xx %): _____

47C. Percent of Type A₂ hemoglobin (xx %): _____

48. What is the patient's date of birth (yyyy/mm/dd)? _____

48A. Patient's birth weight (xx.x lbs.): _____

48B-1. Patient's gestational age - weeks (xx): _____

48B-2. Patient's gestational age - days (x): _____

49. What is the patient's gender?
- ☐ Male
- ☐ Female

50. What is the patient's baseline oximetry reading (xxx %)? (sitting at rest in outpatient hematology clinic for at least 3 minutes and with no current illness) _____

51. Most recent vital signs during well child visit:

51A. Visit date (yyyy/mm/dd): _____

51B. Pulse rate (xxx beats/minute): _____

51C-1. Blood pressure - systolic (xxx mmHg): _____

51C-2. Blood pressure - diastolic (xxx mmHg): _____

51D. Respirations (xx breaths/minute): _____

51E. Temperature - unit:
- ☐ Conventional: Degrees, Fahrenheit
- ☐ SI: Degrees, Celsius

51E-1. Temperature (xxx.x degrees, Fahrenheit): _____

51E-1. Temperature (xx.x degrees, Celsius): _____

51F. Height - unit:
- ☐ Conventional: Inches (in.)
- ☐ SI: Centimeters (cm.)

51F-1. Height (xx in.): _____

51F-1. Height (xxx cm.): _____

51G. Weight - unit:
- ☐ Conventional: Pounds (lbs.)
- ☐ SI: Kilograms (Kg.)

51G-1. Weight (xxx lbs.): _____

51G-1. Weight (xxx Kg.): _____

52. Current status:

52A-1. HIV antibody test:
- ☐ Positive
- ☐ Negative
- ☐ Not tested

52A-2. Year (yyyy): _____

52B-1. Hepatitis A antibody (lgG):
- ☐ Positive
- ☐ Negative
- ☐ Not tested

52B-2. Year (yyyy): _____

52C-1. Hepatitis B surface antigen

- ☐ Positive
- ☐ Negative
- ☐ Not tested

52C-2. Year (yyyy): _____

52D-1. Hepatitis B core antigen (lgG):

- ☐ Positive
- ☐ Negative
- ☐ Not tested

52D-2. Year (yyyy): _____

52E-1. Hepatitis C antibody:

- ☐ Positive
- ☐ Negative
- ☐ Not tested

52E-2. Year (yyyy): _____

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53. Current Medications and Treatment (answer each item):

53A. Penicillin:

- ☐ Yes
- ☐ No

53B. Folic Acid:

- ☐ Yes
- ☐ No

53C. Other:

- ☐ Yes
- ☐ No

53C-1. If Other, specify: _____

53D. Other:

- ☐ Yes
- ☐ No

53D-1. If Other, specify: _____

53E. Other:

- ☐ Yes
- ☐ No

53E-1. If Other, specify: _____

53F. Other:

- ☐ Yes
- ☐ No

53F-1. If Other, specify: _____

53G. Other:

- ☐ Yes
- ☐ No

53G-1. If Other, specify: _____

53H. Overnight oxygen:

- ☐ Yes
- ☐ No

54. Record steady state hematology values. Please be sure to record lab values in the units posted on this form.

54A. Date of specimen (yyyy/mm/dd): _____

54B. Hemoglobin - unit:
☐ Conventional: g/dl
☐ SI: mmol/L

54B-1. Hemoglobin (xx.x g/dl): _____

54B-1. Hemoglobin (x.xx mmol/L): _____

54C. Hematocrit (xx %): _____

54D. RBC (xx.x m/mm³): _____

54E. WBC (xxxxx cu): _____

54F. Neutrophils (xx %): _____

54G. Bands (xx %): _____

54H. MCV (xxx.x fl): _____

54I. MCH (xx.x pg): _____

54J. MCHC - unit:
☐ Conventional: g/dl
☐ SI: g/L

54J-1. MCHC (xx g/dl): _____

54J-1. MCHC (xxx g/L): _____

54K. Platelets - unit:
☐ Conventional: X 10³/mm³
☐ SI: X 10⁹/L

54K-1. Platelets (xxxxxxx X 10³/mm³): _____

54K-1. Platelets (xxxxxx X 10⁹/L): _____

54L. MPV (xx.x fl): _____

54M. Reticulocytes - unit:
☐ Conventional: %
☐ SI: Proportion of 1.0

54M-1. Reticulocytes (xx.x %): _____

54M-1. Reticulocytes (x.xxx proportion of 1.0): _____

55. Immunizations (answer each item):

55A. Haemophilus influenzae Type B:
☐ Yes
☐ No
☐ Unknown

55A-1. If Yes, enter year (yyyy): _____

55B. Pneumovax
☐ Yes
☐ No
☐ Unknown

55B-1. If Yes, enter year (yyyy): _____

55C. Meningoccoccus C
- ☐ Yes
- ☐ No
- ☐ Unknown

55C-1. If Yes, enter year (yyyy): _____

55D. Meningoccoccus A:
- ☐ Yes
- ☐ No
- ☐ Unknown

55D-1. If Yes, enter Year (yyyy): _____

55E. Hepatitis B:
- ☐ Yes
- ☐ No
- ☐ Unknown

55E-1. If Yes, enter year (yyyy): _____

55F. Hepatitis A:
- ☐ Yes
- ☐ No
- ☐ Unknown

55F-1. If Yes, enter year (yyyy): _____

55G. Influenza vaccine:
- ☐ Yes
- ☐ No
- ☐ Unknown

55G-1. If Yes, enter year (yyyy): _____

55H. Prevnar:
- ☐ Yes
- ☐ No
- ☐ Unknown

55H-1. If Yes, enter year (yyyy): _____

---

56. Patient's past medical history:

56A. Dactylitis:
- ☐ Yes
- ☐ No

56A-1. If Yes, number of events (xx): _____

56A-2. Age at first dactylitis event (xx): _____

56B. Splenic sequestration (acute) (xx):
- ☐ Yes
- ☐ No

56B-1. If Yes, number of events (xx): _____

56B-2. Age at first splenic sequestration (xx): _____

56C. Documented UTI:
- ☐ Yes
- ☐ No

56C-1. If Yes, number of events (xx): _____

56D. Aplastic crisis/Parvovirus:
- ☐ Yes
- ☐ No

56D-1. If Yes, enter year (yyyy): _____

56E. Salmonella infection:
- ☐ Yes
- ☐ No

56E-1. If Yes, enter year (yyyy): _____

57F. Pneumococal meningitis:
- ☐ Yes
- ☐ No

56F-1. If Yes, enter year (yyyy): _____

56G. Meningococal meningitis:
- ☐ Yes
- ☐ No

56G-1. If yes, enter year (yyyy): _____

56H. Other bacterial meningitis:
- ☐ Yes
- ☐ No

56H-1. If Yes, enter year (yyyy): _____

56I. Non-bacterial meningitis (i.e., viral):
- ☐ Yes
- ☐ No

56I-1. If Yes, enter year (yyyy): _____

56J. Priapism:
- ☐ Yes
- ☐ No
- ☐ NA

56J-1. If Yes (yyyy):
- ☐ Stuttering < 24 hours
- ☐ Stuttering >= 24 hours
- ☐ Continuous < 24 hours
- ☐ Continuous >= 24 hours

56K. Avascular necrosis:
- ☐ Yes
- ☐ No

56K-1. If Yes, check all that apply:
- ☐ Right hip
- ☐ Left hip
- ☐ Right shoulder
- ☐ Left shoulder

56L. Common bile duct obstruction:
- ☐ Yes
- ☐ No

56M. Central venous line:
- ☐ Yes
- ☐ No

56N. Highest total bilirubin in the last three years, when patient is well - unit:
- ☐ Conventional: mg/dL
- ☐ SI: µmol/L

56N-1. Highest total bilirubin in the last three years, when patient is well - value (xxx.x mg/dL): _____

56N-1. Highest total bilirubin in the last three years, when patient is well - value (xxx.x µmol/L): _____

56O. Baseline creatinine - unit:
- ☐ Conventional: mg/dL
- ☐ SI: µmol/L

56O-1. Baseline creatinine - value (xxx.x mg/dL): _____

56O-1. Baseline creatinine - value (xxx µmol/L): _____

56P. Baseline BUN - unit:
- ☐ Conventional: mg/dL
- ☐ SI: mmol/L

56P-1. Baseline BUN - value (xxx.x mg/dL): _____

56P-1. Baseline BUN - value (xx.xx mmol/L): _____

56Q-1. Highest blood pressure in the last year - systolic (xxx mmHg): _____

56Q-2. Highest blood pressure in the last year - diastolic (xxx mmHg): _____

57. Past Surgeries: To the best of your knowledge, has the patient ever had any of the following surgeries? If the patient has had the same surgery in two different years, please record each surgery on a separate line.

57A. Tonsillectomy/Adenoidectomy:
- ☐ Yes
- ☐ No
- ☐ Don't know

57A-1. If yes, enter year (yyyy): _____

57B. Splenectomy:
- ☐ Yes
- ☐ No
- ☐ Don't Know

57B-1. If Yes, enter year (yyyy): _____

57C. Cholecystectomy:
- ☐ Yes
- ☐ No
- ☐ Don't Know

57C-1. If Yes, enter year (yyyy): _____

57D. Other, specify: _____

57D-1. Enter year (yyyy): _____

57E. Other, specify: _____

57E-1. Enter year (yyyy): _____

57F. Other, specify: _____

57F-1. Enter year (yyyy): _____

57G. Other, specify: _____

57G-1. Enter year (yyyy): _____

57H. Other, specify: _____

57H-1. Enter year (yyyy): _____

57I. Other, specify: _____

57I-1. Enter year (yyyy): _____

58. Has the patient experienced any of the following problems during the past three years?

58A. Transient ischemic attack:
- ☐ Yes
- ☐ No

58B. Hospitalization for pain:
- ☐ Yes
- ☐ No

58B-1. If Yes, how many admissions? (xx) _____

58C. Hospitalization for acute chest syndrome (ACS):
☐ Yes
☐ No

58C-1. If Yes, how many admissions? (xx) _____

58D. Hospitalization for asthma/respiratory symptoms:
☐ Yes
☐ No

58D-1. If Yes, how many admissions? (xx) _____

58E. Emergency department visits for pain:
☐ Yes
☐ No

58E-1. If Yes, how many visits? (xx) _____

58F. Emergency department visits for ACS:
☐ Yes
☐ No

58F-1. If Yes, how many visits? (xx) _____

58G. Emergency department visits for asthma/respiratory symptoms:
☐ Yes
☐ No

58G-1. If Yes, how many visits? (xx) _____

Staff I.D. #: _____