FORM
REV

MULTICENTER STUDY OF HYDROXYUREA IN SICKLE CELL ANEMIA (MSH)

DEMOGRAPHICS

CLINIC	CLINIC NO.					
ID	I.D. NO.					-
VISIT	VISIT					1

PART I: IDENTIFYING INFORMATION

1. Patient's NAME CODE:

NAMECODE
___ ___ ___ ___ ___

2. Date:

VIS_DT
___ ___ - ___ ___ ___ - ___ ___
Day Month Year

PART II: ETHNICITY AND GENDER

* 3. Ethnicity: RACE ---------------- ___ N/A (1)

A. Hispanic? ------ (1) Yes (2) No (3)

4. Gender (at birth) -------- ___ (1)

PART III: HOUSING

* 5. The patient's primary residence is a ----------- HOUSE ___ N/A (1)

* 6. How many rooms are in this residence ------- (Not counting kitchen, bathroom, halls or foyers.) ROOMS ___ ___ (1)

PART IV: EDUCATION

* 7. How much school has the patient completed? ------- EDUCATN ___ N/A (1)

PART V: INCOME

* 8. The patient's personal income last year was ----- INCOME_P ___ N/A (1)

* 9. The total income in the patient's household last year was ------------------ INCOME_H ___ N/A (1)

PART VI: FAMILY

10. Patient's marital status: MARITAL

Now married ------------------	(1)
Living as married -------------	(2)
Widowed -----------------------	(3)
Divorced ----------------------	(4)
Separated ---------------------	(5)
Never married -----------------	(6)
N/A ---------------------------	(7)

11. Total number of persons in household --------------- PERSONS ___ ___ N/A (1)

PART VII: MEDICAL CARE RESOURCES

12. Patient's medical coverage (answer each item):

		Yes	No	N/A
PRIVINS	A. Private insurance ----	(1)	(2)	(3)
MEDICARE	B. Medicare -------------	(1)	(2)	(3)
MEDICAID	C. Medicaid -------------	(1)	(2)	(3)
STATINS	D. State program --------	(1)	(2)	(3)

PART VIII: EMPLOYMENT

*13. Employment status ------------- EMPLYMNT ___ N/A (1)

A. If not currently employed, time since last employed?

___ ___ yrs ___ ___ mos N/A (1)
UNEMP_YR UNEMP_MO

I.D. No.					-	

14. Has the patient been employed within the last five years? --- (1) Yes (2) No (3) N/A — EMP-5YRS

If NO or N/A, skip to Item 17.

*15. What is/was the patient's main occupation? (What kind of work does/did the patient usually do?) - ___ N/A (1) — OCCUPATN

*16. What kind of place does/did the patient work for? (What do/did they make or do?) -------------------- ___ N/A (1) — INDUSTRY

17. Total years of part or full-time work ---- ___ ___ N/A (1) — YRS-WRKD

PART IX: COORDINATION

18. Checked for completeness and accuracy:

A. Certification Number: __ __-__ __

B. Signature:

____

Retain a copy of this form for your files. Send the original to the MSH Data Coordinating Center. Use MSH mailing labels:

MSH Data Coordinating Center
Maryland Medical Research Institute
600 Wyndhurst Avenue
Baltimore, Maryland 21210

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