

HEIRS MEDICAL HISTORY FORM

Participant ID	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">□</td> </tr> <tr> <td colspan="10" style="text-align: center; font-size: small;">[affix ID label here]</td> </tr> </table>	□	□	□	□	□	□	□	□	□	□	[affix ID label here]										Date of Visit	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">□</td> </tr> </table>	□	□	□	□	□	□
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Part 1: Symptoms and Signs

Have you experienced or had any of the following during the past 12 months?

- | | | | |
|--|--------------------------------|-------------------------------|---------------------------------------|
| 1. Swelling of feet or ankles | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 2. Change in skin color | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 3. Unexplained weight loss | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 4. Abdominal swelling or fluid | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 5. <i>For men only:</i> | | | |
| Trouble having an erection or loss of sexual drive | <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |

Have you been repeatedly bothered by any of the following?

- | | | | |
|--|--------------------------------|-------------------------------|---------------------------------------|
| 6. Chronic fatigue/weakness | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 7. Shortness of breath | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 8. Joint stiffness/pain/ache | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 9. Excessive thirst | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 10. Polyuria (excessive urination) | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 11. Unexplained abdominal pain or discomfort | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 12. Unexplained confusion or memory loss | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |

Part 2: Medical History Information

The following are some questions about your medical history. Some of the questions may refer to things that happened or began long ago, and/or certain information may be sensitive for you to answer. However, your input is very valuable to the study; please answer each question to the best of your ability. If you do not understand a question or word, leave the question blank and ask the Interviewer.

Has a doctor ever told you that you have or had any of the following:

- | | | | |
|---|--------------------------------|-------------------------------|---------------------------------------|
| 13. Iron overload or hemochromatosis | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 14. Anemia (low blood) | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 15. Sickle cell anemia | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 16. Thalassemia or other inherited anemia | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |
| 17. Unusual blood loss (vomiting or coughing up blood, blood in stool, or blood in urine) | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No | 3 <input type="checkbox"/> Don't know |

Has your doctor ever told you that you have any of the following?

18. Diabetes

- 1 Yes (if yes →)
 2 No
 3 Don't know

18a. Are you taking medicine for this?

- 1 Yes (if yes →)
 2 No

18b. Insulin 1 Yes 2 No

18c. Pills 1 Yes 2 No

18d. At what age was this first treated? years old

19. Liver disease

- 1 Yes (if yes →)
 2 No
 3 Don't know

Which type? (check one box per line)

19a. Fatty liver

1 Yes 2 No 3 Don't Know

19b. Cirrhosis

1 Yes 2 No 3 Don't know

19c. Liver cancer

1 Yes 2 No 3 Don't know

(cancer that started in the liver)

19d. Hepatitis

- 1 Yes (if yes →)
 2 No
 3 Don't know

19e. Check all that apply

- 1 Type A 2 Type B
 3 Type C 4 Other

20. Thyroid disease (over-active or under-active thyroid)

1 Yes 2 No 3 Don't know

21. Heart failure or weak heart

1 Yes 2 No 3 Don't know

22. Abnormal heart rhythm, heart beat or action/arrhythmia

1 Yes 2 No 3 Don't know

23. Other heart disease or heart attack

1 Yes 2 No 3 Don't know

24. Arthritis

1 Yes 2 No 3 Don't know

25. Osteoporosis (weak, thin, or brittle bones)

1 Yes 2 No 3 Don't know

26. Porphyria cutanea tarda (blistering skin rash made worse by sunlight)

1 Yes 2 No 3 Don't know

27. HIV or AIDS

1 Yes 2 No 3 Don't know

28. Chronic inflammation, chronic infection, autoimmune disease or lupus

1 Yes 2 No 3 Don't know

29. Cancers (other than those starting in the liver)

- 1 Yes (if yes →)
 2 No
 3 Don't know

29a. Specify:

30. Chemotherapy or bone marrow transplant

1 Yes 2 No 3 Don't know

Part 3: Reproductive History For Women Only – Men skip to question #37**31. Have you ever seen a doctor for:**

- 31a. Menstrual problems 1 Yes 2 No 3 Don't know
 31b. In-between bleeding 1 Yes 2 No 3 Don't know
 31c. Early stopping of periods 1 Yes 2 No 3 Don't know

32. Have you ever been pregnant?

- 1 Yes (if yes →) 32a. Number of pregnancies:
 2 No
 3 Don't know 32b. Number of live births:

33. Are you currently pregnant?

- 1 Yes 2 No 3 Don't know

34. Have you gone through menopause?

- 1 Yes (if yes →) 34a. At what age?
 2 No
 3 Don't know

35. At what age did you experience menarche (first menstrual period)?

36. Have you had a hysterectomy? (Uterus or womb removed)

- 1 Yes (if yes →) 36a. At what age?
 2 No
 3 Don't know

Part 4: Blood Transfusion and Donation Information**37. Have you ever had blood transfusions?**

- 1 Yes (if yes →) 37a. Total number of pints/units in a lifetime?
 2 No
 3 Don't know

38. Have you ever donated whole blood at a blood bank?

- 1 Yes (if yes →) 38a. How many units in lifetime?
 2 No
 3 Don't know

Part 5: Lifestyle Information**39. Do you get short of breath:**

- 39a. While resting in a chair? Yes No
- 39b. When walking on level ground? Yes No
- 39c. When walking quickly or uphill? Yes No Never do this

40. Have you ever consumed alcoholic beverages? Yes No → If no go to Q 43

41. How old were you when you first started drinking alcoholic beverages?

42. Do you currently drink alcoholic beverages?

- Yes (if yes →)
- No (if no →)
- | | |
|---|---|
| 42a. For how many years did you drink alcoholic beverages? | <input type="text"/> <input type="text"/> |
| 42b. For how many years did you drink alcoholic beverages? | <input type="text"/> <input type="text"/> |
| 42c. What was the usual number of drinks you had per week before you stopped drinking alcoholic beverages?
<i>(One drink equals 1 beer, 1 glass of wine, 1 shot of liquor, or 1 mixed drink. Record 0, if less than one drink per week.)</i> | <input type="text"/> <input type="text"/> |

Part 6: Demographics

The frequency of iron overload and its health effects may differ by age, gender, race and ethnicity. Please answer these questions about yourself, so we can look at these factors.

43. What is the highest grade of school you've completed?

- Less than high school High school degree
- Some university, college or vocational training Bachelor's degree (BA/BS)
- Post-graduate training

If you were invited to participate as a family member of another participant please answer the following.

44. What is your gender? Male Female

45. What is your birthdate? / /
Month Day Year

46. Are you Spanish, Latino, or Hispanic? Yes No

47. Which of these broad categories best describes your race? (you may check more than one)

- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or other Pacific Islander
- White