

Adult Polyglucosan Body Disease Registry: Participant Data

Contact Information

First Name	
Middle name	
Last name	
Suffix (Jr., III, etc.)	
Mailing address	
Phone number	
Email address	
Preferred method of contact	<input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Phone

Basic information

Date of birth (mm/dd/yyyy)	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Transsexual
Race	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other
Hispanic	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ashkenazi Jewish	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
Mother's country of birth	
Father's country of birth	
Grandmother's country of birth (mother's side)	
Grandfather's country of birth (mother's side)	
Grandmother's country of birth (father's side)	
Grandfather's country of birth (father's side)	
Parents consanguineous	<input type="checkbox"/> No <input type="checkbox"/> Yes
Insurance	<input type="checkbox"/> Private health insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-gap <input type="checkbox"/> Medicaid <input type="checkbox"/> SCHIP (Children's Health Insurance Program) <input type="checkbox"/> Military health care (Tricare/VA, Champ-VA) <input type="checkbox"/> Indian health service <input type="checkbox"/> State-sponsored health plan <input type="checkbox"/> Other government program <input type="checkbox"/> Single service plan (e.g. dental, vision, prescription) <input type="checkbox"/> No coverage

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Basic information, cont'd.

Highest education completed/graduated	<input type="checkbox"/> Eighth grade or less <input type="checkbox"/> More than eighth grade, but did not graduate from high school <input type="checkbox"/> Went to a business, trade, or vocational school instead of high school <input type="checkbox"/> High school graduate <input type="checkbox"/> Completed a GED <input type="checkbox"/> Went to a business, trade, or vocational school after high school <input type="checkbox"/> Went to college, but did not graduate <input type="checkbox"/> Graduated from a college or university <input type="checkbox"/> Professional training beyond a four-year college or university <input type="checkbox"/> Never went to school
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Diagnosis/History

Diagnosed with APBD	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Age at symptom onset									
Age at diagnosis									
Any history of APBD in the family?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know If Yes: <table style="width: 100%; margin-left: 20px;"> <tr> <td></td> <td> <input type="checkbox"/> Yes <input type="checkbox"/> Don't know </td> </tr> <tr> <td style="text-align: center;">Was your mother diagnosed with APBD?</td> <td> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know </td> </tr> <tr> <td style="text-align: center;">Any siblings diagnosed with APBD?</td> <td> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know </td> </tr> <tr> <td style="text-align: center;">Any other relatives diagnosed with APBD?</td> <td> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know </td> </tr> </table>		<input type="checkbox"/> Yes <input type="checkbox"/> Don't know	Was your mother diagnosed with APBD?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	Any siblings diagnosed with APBD?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	Any other relatives diagnosed with APBD?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
	<input type="checkbox"/> Yes <input type="checkbox"/> Don't know								
Was your mother diagnosed with APBD?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know								
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Any other relatives diagnosed with APBD?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know								
Diagnosed with peripheral neuropathy	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Diagnosed with spinal stenosis	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Diagnosed with ALS	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Diagnosed with MS	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Diagnosed with prostate cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Diagnosed with benign prostate hyperplasia (BPH)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes								