PATIENT FORM

Patient ID#:_____
(Office use only)

Birth Place (City, Country)

Gender: ☐Male ☐Female **Are you a multiple Birth?** ☐Yes☐No
Specify : _____
(Twin, Triplet etc.)

Diagnosis:

☐ Giant Cell Arteritis (GCA)
☐ Takayasu's Arteritis
☐ Polyarteritis Nodosa
☐ Granulomatosis with Polyangiitis (GPA)
☐ Microscopic Polyangiitis (MPA)
☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA)

Date of onset of symptoms: _____

Date of diagnosis:_____

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca

Physician who diagnosed your disease:

Name: _____

Address: _____

Telephone # _____

Physician (etc. nephrologist, rheumatologist) who is currently treating your disease and who has access to your medical history and current records:

☐ Same as above, OR:

Name: _____

Address: _____

Telephone # _____

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca

PATIENT FORM (continued)

Marital Status:

☐Single ☐Married ☐Widow(er) ☐Separated ☐Divorced

Education: (check off the highest level completed)

☐No formal schooling ☐Primary ___yrs ☐ Secondary___yrs

☐Post Secondary Degree: ☐Bachelor's ☐Master's ☐Ph. D. ☐Other

Employment Status:

☐Employed ☐Unemployed ☐Disability Insurance

☐ Retired ☐ Retired on Disability ☐ Retired due to Vasculitis or other related illness

Occupation:

Primary : _____ Current: _____

Alcohol Intake: Number of drinks per month _____

Smoking Status: ☐Current Smoker ☐Ex-Smoker ☐Never Smoked

Stress – Major Life Event: (within one year prior to diagnosis)

a) Psychological:

☐death ☐divorce/separation

☐family stress ☐financial stress

b) Physical:

☐motor vehicle accident ☐other injury

☐surgery ☐major infection

FEMALE PATIENTS *ONLY*:

Oral Contraceptive: ☐current ☐previous ☐ never

Pregnancy History: # of pregnancies _____ # of live births _____

Menopause: ☐Yes ☐No If yes, age at onset: _____

Hormone Replacement Therapy:

Current : ☐No If Yes: ☐estrogen alone ☐estrogen and progesterone

Previous: ☐No If Yes: ☐estrogen alone ☐estrogen and progesterone

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca

PATIENT ETHNICITY FORM

Patient ID#: _____

Please check **all** that apply:

Your Ethnicity and Dietary Information:

☐White ☐Black ☐ Asian ☐Hispanic ☐Jewish ☐European ☐African ☐ East Indian

☐North American Indian ☐Other – Please specify _____

☐If Jewish, specify whether ☐Ashkenazai ☐Sephardic

Birth Country:_____

Dietary information: ☐kosher ☐vegetarian ☐celiac/gluten ☐lactose intolerance

☐Other – Please specify _____

Your Mother's Ethnicity and Dietary Information:

☐White ☐Black ☐Asian ☐Hispanic ☐ Jewish ☐European ☐African ☐ East Indian

☐ North American Indian ☐ Other – Please specify _____

☐If Jewish, specify whether ☐Ashkenazai ☐Sephardic

Birth Country:_____

Dietary information: ☐kosher ☐vegetarian ☐ celiac/gluten ☐lactose intolerance

☐Other – Please specify _____

Your Father's Ethnicity and Dietary Information:

☐White ☐Black ☐Asian ☐Hispanic ☐Jewish ☐European ☐African ☐East Indian

☐ North American Indian ☐Other – Please specify _____

☐If Jewish, specify whether ☐Ashkenazai ☐Sephardic

Birth Country:_____

Dietary information: ☐kosher ☐vegetarian ☐celiac/gluten ☐ lactose intolerance

☐Other – Please specify _____

Please add any comments about your ethnicity that you feel would be helpful to us:

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca

PATIENT'S FAMILY FORM

The following section is <u>optional</u>. Please only fill in contact information of family members if you have obtained their permission to do so.** As this is a genetic study, it is important to look at family linkages. We may be contact persons listed below to ask if they would be willing to provide us with a blood sample to compare to yours**.

Please list your children in order of birth, include married names of your daughters:

NAME & RELATIONSHIP TO YOU	ADDRESS	TELEPHONE #	BIRTH DATE DD/MM/YYYY	DIAGNOSED WITH VASCULITIS
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no

Please list your sisters and brothers in order of birth (include last names)
(note if deceased)

NAME & RELATIONSHIP TO YOU	ADDRESS	TELEPHONE #	BIRTH DATE DD/MM/YYYY	DIAGNOSED WITH VASCULITIS
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca

PATIENT'S PARENT FORM – *MOTHER*

Please fill in the following where applicable.
Please note if deceased Patient ID#: _____

(Office use only)

Last Name, First Name

Address (include postal code)

Home Phone # (include area code) Business # (include area code)

_____ Diagnosed with Vasculitis Yes/ No
Date of Birth

Please list your ***Mother's*** sisters and brothers in order of birth (include last names) (**note if deceased**)

NAME & RELATIONSHIP TO YOU	ADDRESS	TELEPHONE #	BIRTH DATE DD/MM/YYYY	DIAGNOSED WITH VASCULITIS
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca

PATIENT'S PARENT FORM – *FATHER*

Please fill in the following where applicable.
Please note if deceased Patient ID#: _____

(Office use only)

Last Name, First Name

Address (include postal code)

Home Phone # (include area code) Business # (include area code)

_____ Diagnosed with Vasculitis Yes / No
Date of Birth (DD/MM/YYYY)

Please list your ***Father's*** sisters and brothers in order of birth (include last names) **(note if deceased**)

NAME & RELATIONSHIP TO YOU	ADDRESS	TELEPHONE #	BIRTH DATE DD/MM/YYYY	DIAGNOSED WITH VASCULITIS
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no
			/ /	yes / no

600 University Ave. Rm 778D, Toronto, ON M5G 1X5
Tel.: (416) 586-4800 x5492 Fax: (416) 586-5132
Email: robyn.chensang@uhn.ca