

Form 1

Demographics and Contact Information

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MORPHEA Registry and DNA Repository

I have read the description of the study and I have decided to participate in the research project described here. I understand that I may refuse to answer any (or all) of the questions at this time or any other time. I understand that I will be contacted on an annual basis in the future about this, but that I am free to refuse any further participation if I wish.

Date: ___ / ___ / _____

Name: _____
Last First Middle

I am registering as a pediatric CONTROL, unaffected person, non blood-related to anyone with morphea and with no history of an autoimmune disease: No Yes

I am filling this form out for Myself My child

If you are filling this out for someone else, please give your name: _____
Last First

If someone in your family with morphea has already registered, please give his/her name so that the computer can connect relatives.

Name: _____ I am this person's: _____
Last First

Date of Birth: ___ / ___ / _____ (of registrant)

Are you a twin? No Yes: Fraternal Identical Unknown Triplets

Are you adopted? No Yes

Place of Birth: _____

Primary Contact Address: _____

City/State/Zip: _____

E-mail: _____

Telephone number: Home _____ Work _____

Mobile: _____ Fax: _____

Sex: Male Female

Race/Ethnicity: White African American Hispanic/Latino Asian/Pacific Islander

American Indian/Alaskan Native Mixed Race: Other:

Current Occupation: _____

Number of years _____

Prior occupations: _____
