Lipodystrophy Demographic and Health History Questionnaire

I. GENERAL INFORMATION

Today's Date _ _ (Month) _ _ (Day) _ _ _ _ (Year)

1. NAME: ____
   Last First MI Maiden

2. ADDRESS: ____
   Street Number

   CITY: ____________________ STATE: ____________ ZIP: ______________

3. PHONE NUMBER: (Home) ____________________________
   (Area Code) Number

   (Work) ____________________________
   (Area Code) Number

   (Cell) ____________________________
   (Area Code) Number

4. EMERGENCY CONTACT: ____________________________
   Name

   PHONE NUMBER: ____________________________
   (Area Code) Number

5. EMAIL ADDRESS: ______________________________________

   CONTACT: May we contact you with lab/study results at the following numbers/locations?

	YES	NO	Preferred
Home	☐	☐	☐
Work	☐	☐	☐
Cell/Pager	☐	☐	☐
Email	☐	☐	☐
Mail	☐	☐	☐

6. BIRTHDATE: _ _ (Month) _ _ (Day) _ _ _ _ (Year)

7. GENDER/SEX: ☐ Male ☐ Female

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8. BIRTHPLACE: ____
City State or Country

9. EDUCATION:

- ☐ Grade School (6 years or less)
- ☐ Junior High (7-9 years)
- ☐ High School (10-12 years)
- ☐ Vocational Training (beyond HS)
- ☐ Some College
- ☐ College Degree
- ☐ Graduate or Professional
- ☐ Education

10. ETHNIC CATEGORIES: Mark only one

- ☐ ***Hispanic*** *or* ***Latino*** (A person of Cuban, Mexican, Puerto Rican, South/Central American or other Spanish-speaking culture regardless of race)
- ☐ ***Not Hispanic*** *or* ***Latino***

RACIAL CATEGORIES: Mark all that apply

- ☐ ***Black*** *or* ***African American*** (any black African racial origins including Haitians)
- ☐ ***Asian*** (Far East, Southeast Asia or Indian Subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam)
- ☐ ***Native Hawaiian*** *or other* ***Pacific Islander*** (any origins from Hawaii, Guam, Somoa or other Pacific Islands, specifically not the Philippine Islands)
- ☐ ***American Indian*** *or* ***Alaskan Native*** (any origins from the *original peoples* of *North*, *Central*, and *South* America)
- ☐ ***White*** (any origins from original peoples of Europe, Near/Middle East, or North Africa including Hispanics and Latino of these races)

11. ANCESTOR'S ORIGIN: Mother______________________ (Country)
Father ______________________ (Country)

II. MEDICAL INFORMATION

12. NAME OF PHYSICIAN: ________________________________

13. ADDRESS OF PHYSICIAN: ____
Street Number

CITY:____________________ STATE:__________________ ZIP:__________

14. PHONE NUMBER OF PHYSICIAN: ________________________
(Area Code) Number

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III. PAST MEDICAL HISTORY

Have you ever had:	YES	NO	Don't Know	If yes, specify age of onset
15. High Cholesterol	☐	☐	☐	____________
16. High Triglycerides	☐	☐	☐	____________
17. Diabetes	☐	☐	☐	____________
18. Heart Disease				
a. Angina	☐	☐	☐	____________
b. Heart Attack	☐	☐	☐	____________
c. Heart Failure	☐	☐	☐	____________
d. Heart Murmur	☐	☐	☐	____________
e. Irregular Heart Beat / Slow Heart Beat	☐	☐	☐	____________
	☐	☐	☐	____________
f. Pacemaker	☐	☐	☐	____________
19. Stroke	☐	☐	☐	____________
20. Claudication (pain in legs while walking)	☐	☐	☐	____________
21. Xanthomas (cholesterol deposits on skin or tendons)	☐	☐	☐	____________
22. Cancer	☐	☐	☐	____________
23. Kidney Problems	☐	☐	☐	____________
a. Proteinuria (Protein present in the urine)	☐	☐	☐	____________
24. Hemodialysis	☐	☐	☐	____________
25. High Blood Pressure	☐	☐	☐	____________
26. Problems with your bowels	☐	☐	☐	____________
27. Pancreatitis	☐	☐	☐	____________
28. Arthritis	☐	☐	☐	____________
29. Skin Condition	☐	☐	☐	____________
30. Overactive Thyroid (hyperthyroidism)	☐	☐	☐	____________
31. Underactive Thyroid (hypothyroidism)	☐	☐	☐	____________
32. Anorexia Nervosa	☐	☐	☐	____________

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33. Bulimia ☐ ☐ ☐ ____________________

34. Psychiatric Problems ☐ ☐ ☐ ____________________

35. Drug Allergies ☐ ☐ ☐ ____________________
If yes, please list____________________
____

36. Other Allergies ☐ ☐ ☐ ____________________
If yes, please list____________________
____

37. If you are a woman,
a. At what age did you begin to menstruate? _______________ (Years)

b. When did you have your last menstrual period? _______________ (Years)

c. Do you have irregular menstrual periods? ☐ Yes ☐ No

d. How many pregnancies? ________ Please give dates ____________________________

e. Did any pregnancy result in a miscarriage? ☐ Yes ☐ No

1. If yes, please give dates __________________________

f. If no pregnancies, did you spend greater than one year trying to conceive? ☐ Yes ☐ No

g. Do you have increased facial or body hair? ☐ Yes ☐ No

h. Have you had polycystic ovarian syndrome? ☐ Yes ☐ No

IV. FAMILY MEDICAL HISTORY

	Yes	No	Don't Know	Family Member
a. Lipodystrophy	☐	☐	☐	______________
b. Heart Disease	☐	☐	☐	______________
c. Stroke	☐	☐	☐	______________
d. Hypertension	☐	☐	☐	______________
e. Asthma	☐	☐	☐	______________
f. Diabetes	☐	☐	☐	______________
g. Cancer	☐	☐	☐	______________
h. Kidney Disease	☐	☐	☐	______________
i. Blood Disorder	☐	☐	☐	______________
j. Unusual Body Shape	☐	☐	☐	______________
k. Other ____________________________	☐	☐	☐	______________

V. PRIOR HOSPITALIZATIONS

Have you ever been hospitalized for one of the following conditions:	YES	NO	Age at Admission
38. Angina Pectoris	☐	☐	____________
39. Heart Attack	☐	☐	____________
40. Coronary Angiography	☐	☐	____________
41. Heart Bypass Surgery	☐	☐	____________
42. Percutaneous Trans-Luminal Coronary Angioplasty	☐	☐	____________
43. Carotid Artery Surgery	☐	☐	____________
44. Graft of Blood Vessel in Arms or Legs	☐	☐	____________

VI. DATES OF HOSPITAL ADMISSIONS OR PROCEDURES

(Heart Attack, Cardiac Catheterization, Heart Surgery, Stroke, Pancreatitis, Gall Bladder Surgery, Plastic or Reconstructive Surgery, Other Surgeries or Other Medical Problems)

Problem or Procedure	Year	Where Hospitalized

VII. SMOKING / DRINKING HISTORY

45. Did you ever smoke? ☐ Yes ☐ No

If yes,

a. How many packs/day at the most? ☐ 0-½ ☐ ½-1 ☐ 1-1½ ☐ 1½-2 ☐ >2

b. How old were you when you started? ______________ (Years)

c. Do you still smoke? ☐ Yes ☐ No

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If yes,
d. How many packs/day? ☐ 0-½ ☐ ½-1 ☐ 1-1½ ☐ 1 ½-2 ☐ >2

If no,
e. How old were you when you stopped? _______________ (Years)

46. Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes
a. How many drinks/week on average?_____________ (assume that 1 drink is equal to 12 oz. Beer, 4 oz. Wine or 1 oz. Hard Liquor)

VIII. DIET AND EXERCISE

47. Height: ____________________ (Feet/Inches)

48. Weight: ____________________ (Pounds)

49. Were you overweight as a child? ☐ Yes ☐ No

50. What has been your maximum weight excluding any pregnancies? ______________ (Pounds)

51. At what age were you at your maximum weight? _______________ (Years)

52. Do you follow a special diet? ☐ Yes ☐ No

If yes, please specify type and give general details

a. ☐ Low cholesterol or low fat ____

b. ☐ Diabetic ____

c. ☐ Low salt ____

d. ☐ Weight reduction ____

e. ☐ Vegetarian ____

f. ☐ Other ____

53. Do you participate in regular exercise programs? ☐ Yes ☐ No

If yes, please specify type of program and duration __________________________________
Type Hours/Week

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IX. MEDICATIONS

	Yes	No	If yes, please specify
54. Are you on birth control pills now?	☐	☐	____________
55. Are you taking any hormones?	☐	☐	____________
a. Thyroid	☐	☐	____________
b. Estrogen	☐	☐	____________
c. Progesterone	☐	☐	____________
d. Steroids	☐	☐	____________
e. Anabolic steroids, (i.e. testosterone)	☐	☐	____________
f. Others____________	☐	☐	
56. Are you taking or have you taken any lipid lowering drugs?	☐	☐	____________
a. Niacin (nicotinic acid)	☐	☐	____________
b. Colestipol, Cholestyramine	☐	☐	____________
c. Lopid (Gemfibrozil), Tricor (Fenofibrate)	☐	☐	____________
d. Mevacor, Zocor, Pravachol, Lescol, Lipitor, Crestor	☐	☐	____________
e. Fish Oil	☐	☐	____________
f. Zetia	☐	☐	____________
g. Others____________	☐	☐	
57. Do you take medications for high blood pressure or heart disease?	☐	☐	____________
58. Do you take medication to lower your glucose?	☐	☐	____________
a. Insulin	☐	☐	____________
b. Glyburide, Glipizide, Glimepiride	☐	☐	____________
c. Metformin (Glucophage)	☐	☐	____________
d. Rosiglitazone (Avandia)	☐	☐	____________
e. Pioglitazone (Actos)	☐	☐	____________
f. Others____________	☐	☐	
59. Are you taking any antidepressants?	☐	☐	____________
60. Are you taking any anorectic (appetite supressant) drugs?	☐	☐	____________

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61. Please list all medications, including herbs, supplements and over-the-counter products, you are currently taking:

Name	Dose	How You Take It

X. LIPODYSTROPHY

62. Have you been previously diagnosed with lipodystrophy? ☐ Yes ☐ No

If yes,
a. At what age was the diagnosis first made? ________________ (Years)

b. How old were you when you first noticed lipodystrophy? ________________ (Years)

c. Which areas of your body were affected with lack of fat? (check all that apply)

☐ Neck ☐ Face ☐ Arms/Forearms ☐ Chest

☐ Abdomen ☐ Hips ☐ Legs

d. Was there a sequence to the loss of fat in the affected areas? ☐ Yes ☐ No

e. If yes, please note the order by numbering the boxes below.

☐ Neck ☐ Face ☐ Arms/Forearms ☐ Chest

☐ Abdomen ☐ Hips ☐ Legs

f. How old were you when the progression of fat loss ended? __________________ (Years)

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	Yes	No	Don't Know/Explain
63. Do your arms appear muscular?	☐	☐	____________
64. Do your arms show prominent veins?	☐	☐	____________
65. Do your legs appear muscular?	☐	☐	____________
66. Do your legs show prominent veins?	☐	☐	____________
67. Do you have excess fat in some areas of your body? (If yes, please explain)	☐	☐	____________
68. Do you have a double chin?	☐	☐	____________
69. Do you have any abnormal, dark pigmentation (acanthosis nigricans) on your body? Particularly in the nape of the neck, armpits trunk or groin. (If yes, please explain)	☐	☐	____________
70. Do you have an enlarged spleen or liver?	☐	☐	____________
71. Do you have premature graying of hair?	☐	☐	____________
72. Do you have loss of hair?	☐	☐	____________
73. Do you have any muscle weakness?	☐	☐	____________
74. Do you have any bone disorders?	☐	☐	____________
75. Do you have any eye disorders such as cataracts/glaucoma?	☐	☐	____________

THANK YOU FOR PARTICIPATING IN THIS STUDY ON LIPODYSTROPHY

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