CRISPIII
*Execution 1
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Participant ID:	pkdid	Clinical Center	: pccn
Missing Data Codes:	A-Participant Refused	B-Reading Not Possible	C-Institutional Error

Biannual Clinic Visit/Meds and Events

This form is to be completed at Visits 10 and 12.

1.	Date of visit dvdate /	/	
2.	Since last contact, has the participant had	d any illnesses? ilyn 0 □ No 1 □ (Go to #3)	Yes
	If yes, please specify briefly: ill		_
			-
			_
2a.	Have you been newly diagnosed with hype	ertension since last contact? hypert 0 □ No 1 □	Yes
	If yes, Date of diagnosis:II	hypyr	
	How were you diagnosed with hypertensic 3 ☐ Hospital stay 4 ☐ Other Specify:	on? hyphdia 1 ☐ Home BP monitor 2 ☐ Doctor visit hypspc	
0 1.	O'man lant anning the control to the control to		
2b.	Since last contact, have you been told by a doctor or other health professional that you have diabetes or high blood sugar (If female, other than during	0 ☐ No 1 ☐ Yes 2 ☐ Don't 9998 ☐ Know Missing If no or don't know, and male participant, go to 3.	
	pregnancy)? diablowsugar	If no or don't know, and female participant, go to 2c.	
	,	ii no oi don't know, and iomaio participant, go to 20.	
	If yes, date:	Month Day Year diablowsugar diablowsugar diablowsugar diablowsugar diablowsugar diablowsugar	rda
		ii male participant, go to zu.	
2c.	Since last contact, have you been told by a doctor or other health professional	0 □ No 1 □ Yes 2 □ Don't 9998 □	
	that you have/had diabetes during pregnancy? diabpregn	Know Missing If 2c=no or don't know, go to 3.	
	If yes, date:	Month Day Year diabpregnmt diabpregnda diabpregnyr	
2d.	Since last contact, have you taken medications for diabetes?		8 □ sing



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		If yes, medication	ons:		diabmed2 diabmed3 diabmed4	
2e.	Since last contact, have you					
	taken diabetic pills (also called hypoglycemic agents) to lower your blood sugar? diabpills	0 □ No	1 □ Yes	2 □ Don't Know	777 □ Not Applicable	9998 □ Missing
2f.	Since last contact, have you taken insulin?	0 □ No	1 □ Yes	2 Don't Know	777 □ Not Applicable	9998 □ Missing
3.	Since the last contact, has the p	participant visite	ed their primar	v care physician?	0 □ No	1 ☐ Yes
J	pvyn	oartioipant violto	a thon primar	y care priyereran.	(Go to #4)	1 🗀 103
	If yes, complete Section 3 3a. Date of physician visit: pvda Mon	/ /th Day Yea	<i>pvyr</i> ar			
	3b. Were there multiple visits to	this physician?	¹ Mvci		0 □ No	1 ☐ Yes
	3c. Name and address of physi	cian treating pa	rticipant:			
			-			
	Name:					
	Address:					
	City, State, Zip:					
	3d. Specify reason for visit: pvn	eason				



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4.	Since last contact, has the participant visited any physician other than the primary care physician listed in question 3? pvotphyld	0 □ No (Go to #5)	1 ☐ Yes
	If yes, complete Section #4 Physician #1 a. Date of additional physician visit:/		
	b. Were there multiple visits to this physician? m2vc	0 □ No	1 ☐ Yes
	c. Name and address of physician treating participant:		
	Name:		
	Address:		
	City, State, Zip:		
	d. Specify reason for visit: pv2reason		
			······································
	Physician #2		
	a. Date of additional physician visit://		
	b. Were there multiple visits to this physician? m2vc	0 □ No	1 ☐ Yes
	c. Name and address of physician treating participant:		
	Name:		
	Address:		
	, taarooo.		
	City, State, Zip:		
	d. Specify reason for visit: pv2reason		
	u. Specify reason for visit. pvzreason		



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Physician #3 a. Date of additional physician visit:/		
b. Were there multiple visits to this physician? m2vc	0 □ No	1 ☐ Yes
c. Name and address of physician treating participant:		
Name:		
Address:		
City, State, Zip:		
d. Specify reason for visit: pv2reason		
u. Specify reason for visit. pvzreason		
Physician #4		
a. Date of additional physician visit://		
pvzmi pvzda Montin Day Year		
b. Were there multiple visits to this physician? m2vc	0 □ No	1 ☐ Yes
	0 □ No	1 □ Yes
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant:	0 □ No	1 □ Yes
c. Name and address of physician treating participant:		1 □ Yes
		1 □ Yes
c. Name and address of physician treating participant: Name:		
c. Name and address of physician treating participant:		
c. Name and address of physician treating participant: Name:		
c. Name and address of physician treating participant: Name:		
c. Name and address of physician treating participant: Name: Address:		
c. Name and address of physician treating participant: Name: Address: City, State, Zip:		
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c. Name and address of physician treating participant: Name: Address: City, State, Zip:		

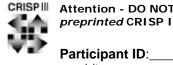


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Physician #7 a. Date of additional physician visit://		
b. Were there multiple visits to this physician? m2vc	0 □ No	1 ☐ Yes
b. Were there multiple visits to this physician? m2vc	U LI NO	i 🗆 res
c. Name and address of physician treating participant:		
Name:		
Address:		
City, State, Zip:		
d. Specify reason for visit: pv2reason		
Physician #8		
a. Date of additional physician visit		
a. Date of additional physician visit:/ /		
b. Were there multiple visits to this physician? m2vc	0 □ No	1 □ Yes
b. Were there multiple visits to this physician? m2vc	0 □ No	1 □ Yes
	0 □ No	1 □ Yes
b. Were there multiple visits to this physician? m2vc		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name: Address:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name: Address: City, State, Zip:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name: Address:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name: Address: City, State, Zip:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name: Address: City, State, Zip:		
b. Were there multiple visits to this physician? m2vc c. Name and address of physician treating participant: Name: Address: City, State, Zip:		



Participant ID:	pkdid	Clinical Center:	рссі

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Physician #9 a. Date of additional physician visit:///		
pv2mt pv2da Month Day Year		
b. Were there multiple visits to this physician? m2vc	0 □ No	1 ☐ Yes
c. Name and address of physician treating participant:		
c. Name and address of physician treating participant.		
Name:		
Address:		
City, State, Zip:		
d. Specify reason for visit: pv2reason		
Physician #10		
a. Date of additional physician visit:///		
b. Were there multiple visits to this physician? m2vc0	0 □ No	1 🗆 Yes
c. Name and address of physician treating participant:		
Name		
Name:		
Aller		
Address:		
00		
City, State, Zip:		
d. Specify reason for visit: pv2reason		



Participant ID: visit:	pkdid	Clinical Center	; pccn
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5. Since last contact, has the participant been hospitalized? hospid	0 □ No (Go to #6)	1 ☐ Yes
If yes, complete Section #5 Hospitalization #1		
a. Was this hospitalization unscheduled? husch	0 □ No	1 ☐ Yes (See Note)
		014.0
Note: If unscheduled, please report the event to the local IRB and se	end a copy to the D	CIAC
b. Date admitted to hospital://		
c. Date discharged from hospital:/ / hdyr		
d. Length of stay (in days) :lenst		
e. Name and address of hospital:		
Name:		
Address:		
City, State, Zip:		
f. Name and address of physician treating participant:		
Name:		
Address:		
City, State, Zip:		
only, state, zip.		
g. What was the discharge diagnosis?		hdiag
h. Was there any renal surgery performed? rsurgpyn If no, go to Hospitalization #2 or Section 6 if no more hospitalizations	0 □ No	1 ☐ Yes
If yes, was the intent cyst reduction? ceducyn	0 □ No	1 □ Yes
i. For any renal surgery provide a date and short description: Date of intervention://		
Description:		rsidesc



Participant ID: visit:	pkdid	Clinical Center	:: pccn
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Hospitalization #2 a. Was this hospitalization unscheduled? husch	0 □ No	1 ☐ Yes (See Note)
Note: If unscheduled, please report the event to the local IRB and send	d a copy to the D	CIAC
b. Date admitted to hospital:/		
c. Date discharged from hospital:// hdmt hdda Month Day Year		
d. Length of stay (in days) :lenst		
e. Name and address of hospital:		
·		
Name:		
Address:		
City, State, Zip:		
f. Name and address of physician treating participant:		
Name:		
Address:		
Address:		
City, State, Zip:		
g. What was the discharge diagnosis?		hdiag
h Was there any renal surgery performed?	O D Na	4 🗖 V
h. Was there any renal surgery performed? resurgpyn If no, go to Hospitalization #3 or Section 6 if no more hospitalizations	0 □ No	1 ☐ Yes
ii iio, go to ricopitalization no ci cootion e ii iio mere ricopitalizatione		
If yes, was the intent cyst reduction? ceducyn	0 □ No	1 ☐ Yes
i. For any renal surgery provide a date and short description:		
i. To any tenai surgery provide a date and short description.		
Date of intervention:// rsiyr rsimt rsida Month Day Year		
Description:		rsidesc
Decomption		



Participant ID:	pkdid	Clinical Center	:: pccn
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Hospitalization #3 a. Was this hospitalization unscheduled? husch	0 □ No	1 □ Yes (See Note)
Note: If unscheduled, please report the event to the local IRB and s	send a copy to the I	DCIAC
b. Date admitted to hospital: J		
c. Date discharged from hospital:/		
d. Length of stay (in days) :/lenst		
e. Name and address of hospital:		
Name:		
Address:		
City, State, Zip:		
f. Name and address of physician treating participant:		
Name:		
Address:		
City, State, Zip:		
g. What was the discharge diagnosis?		hdiag
h. Was there any renal surgery performed? rsurgpyn If no, go to Hospitalization #4 or Section 6 if no more hospitalizations	0 □ No	1 ☐ Yes
If yes, was the intent cyst reduction? ceducyn	0 □ No	1 ☐ Yes
i. For any renal surgery provide a date and short description:		
Date of intervention:/ / rsiyr rsimt rsida Month Day Year		
Description:		rsidesc



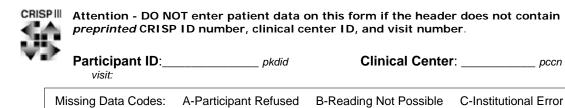
Participant ID: visit:	pkdid	Clinical Center	: pccn
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Hospitalization #4 a. Was this hospitalization unscheduled? husch	0 □ No	1 ☐ Yes (See Note)
Note: If unscheduled, please report the event to the local IRB and se	nd a copy to the [DCIAC
b. Date admitted to hospital:/ hayr hamt hada Month Day Year		
c. Date discharged from hospital:/ / hdyr		
d. Length of stay (in days) :lenst		
e. Name and address of hospital:		
Name:		
Address:		
City, State, Zip:		
f. Name and address of physician treating participant:		
Name:		
Address:		
City, State, Zip:		
g. What was the discharge diagnosis?		hdiag
h. Was there any renal surgery performed? rsurgpyn	0 □ No (Go to #6)	1 ☐ Yes
If yes, was the intent cyst reduction? ceducyn	0 □ No	1 ☐ Yes
i. For any renal surgery provide a date and short description:		
Date of intervention:/		
Description:		rsidesc



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6.	Sm	oking and	d Tobacco:						
	6a.	Has the	participant eve	er smoked ci	garettes? csy	'n		0 □ No (Go to# 6e)	1 ☐ Yes
		.,							
	6b.	2 [☐ Current <i>(Go</i> ☐ Former, quit s☐ Former, quit s☐	since last visi	•	;)			
	6c.	If forme	r smoker, quit o	date:/_ Month	((Go to #6e)			
	64	If curren	t smoker, how	many nacks	ner vear doe	se the narticin	ant		
	ou.	smoke?			per year doo	ss the particip	ant .		
									_
		Has the ntact?	participant use	ed any other	types of tob	acco since las	otytob	0 □ No (Go to #7a)	1 ☐ Yes
							Olylob		
	6f.	If yes, wl	hich types?						
		6g.	Cigars		0 □ No 1 □ Yes	cigar			
		6h	If yes, how man	v cigare cin	oo the last o	antact?	o i o u u u		
		OII.	ii yes, now man	iy Cigai's Siii	ce the last co	Jillact !	Cignini		
		6i.	Pipe		0 □ No 1 □ Yes	pipeyn			
			<u> </u>						
		6j.	Chewing Tob	acco/Snuff	0 ⊔ No 1 □ Yes	chewyn			
7.	Caf	feinated l	Beverages:						
	7a.	Does th	e participant dr	ink caffeina	ted coffee or	tea? cucaff		0 □ No (Go to #7b)	1 ☐ Yes
		15	ala ala timo a la t		the annual control				
		If yes, o Interva	check time interval: cupcaf	al and enter	tne average r	number of caffe	einated 8 ou	unce cups per	
		٥ ٦	7 Per day						
		0 L 1 E 2 E] Per week	Number of	8 ounce cup	s per interval	ccaf	unit	
		Z L							



	7b.	Does the participant drink other caffeinated beverages? cafotby	0 □ No (Go to #7c)	1 ☐ Yes
		If yes, check time interval and enter the average number of caffeinated 12 interval: glassc	ounce portions p	er
		0 ☐ Per day 1 ☐ Per week Number of 12 ounce portions per interval 2 ☐ Per month	_ scafunit	
	7c.	Does the participant drink alcohol? alcdr	0 □ No (Go to #8)	1 ☐ Yes
		If yes, check time interval and enter the average number of alcoholic drink	s per interval: nad	1
		 (1 drink=any of the following: 12 ounces of beer, 4 ounces of wine, 1.5 ounces □ Per day 1 □ Per week Number of drinks per interval alconit 2 □ Per month 	ces liquor)	
8.	Δna	algesic Use History: Record the average number per month over the last ye	ear <i>0–Partici</i> nani	t doesn't use
0.	Aire	angeste ese instery. Accord the average number per mentil ever the last y	car. o=r artioipari	4000111400
	8a.	Acetaminophen tablets: acett	lets: aspi Avg. number per	
	8c.		<i>nsaidt</i> g. number per month	
	8e.	Medical use of marijuana: dum	Ors cox2 Avg. number per n	
9.	Цос	s the participant used recreational drugs in the last year? illdrg	о П. Ма	4 🗆 Vaa
9.	паъ	s the participant used recreational drugs in the last year? marg	0 □ No	1 ☐ Yes
	lf	yes, check all that apply Heroin duh Marijuana duma Methamphetamine dumeth Cocaine duc Other duo		
		If other, specify:		othr



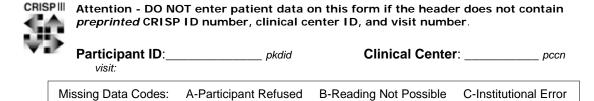
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If this is Visit 10 and the	participant is in Crisp II, or if this is Visit 12, Go to # 11.
If this is Visit 10 and the place of the products/protein su	participant is in Crisp I only, cription medications and all natural pplements,
and then STOP	
Prescribed Medications	pres
presId	
Over the Counter	oct
Medications octld	
All Natural Products/	прр
Protein Supplements	
nppld	



Participant ID:	pkdid	Clinical Center	:: pccn
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11. Prescribed medications changes:			
11a. Since last contact, have prescribed drugs been a	dded? pmald		
If yes, then please record:			
Prescribed Medications added	D	ate (month/year)
pma	dpmamt	/	dpmayr



11b. Since last contact, have prescribed drugs been s	topped/discontinued?	
pmdld		
If yes, then please record:		
Prescribed Medications discontinued	Date (month	/year)
pmd		
	dpmdmt/	dpmdyr

CRIS	Attention Do	•	on this form if the heade enter ID, and visit number	
₩.	Participant ID	pkdid	Clinical Center	:: pccn
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12. (Over-the-counter medications changes:			
1	12a. Since last contact, have OTC drugs been added?	omald		
	If yes, then please record:			
1	n yes, men please record.			
OTC N	Medications added	Da	ate (month/year	·)
oma		domamt	/	domayr
	12b. Since last contact, have OTC drugs been stopped	1/discontinued?		
		omdld		
	If yes, then please record:			
OTC I	Medications discontinued	Da	ate (month/year	·)
omd		domdmt	/	_ domdyr

13.	Natural Product Use Changes:			
		Supplements been	addad2	-1.4
	13a. Since last contact, have Natural Products/Protein	Supplements been a	added? nm	ald
	If yes, then please record:			
Nati	ural Products/Protein Supplements added	Date	e (month/year)	
nma		dnmamt	/	dnmayr
				,
	13b. Since last contact, have Natural Products/Protein nmdld If yes, then please record:	Supplements been	stopped/disc	ontinued?
Nati	ural Products/Protein Supplements discontinued	Date	e (month/year)	
Natu	ural Products/Protein Supplements discontinued		e (month/year)	
	ural Products/Protein Supplements discontinued	Date	e (month/year)	dnmdyr
	ural Products/Protein Supplements discontinued		e (month/year)	
	ural Products/Protein Supplements discontinued		e (month/year)	
	ural Products/Protein Supplements discontinued		e (month/year)	
	ural Products/Protein Supplements discontinued		e (month/year)	
	Please review all contact information on the Identification email address.	dnmdmt		
	Please review all contact information on the Identification email address.	dnmdmt		
	Please review all contact information on the Identification email address. CRISP Member completing this form	dnmdmt		
	Please review all contact information on the Identification email address.	Form including phone	e number and	dnmdyr
	Please review all contact information on the Identification email address. CRISP Member completing this form	Form including phone didnum	e number and	dnmdyr