

Research Registry for Neonatal Lupus (RRNL)

Enrollment Questionnaire

for

Fathers of Neonatal Lupus (NL)-affected children

**National Institute for Arthritis, Musculoskeletal, and
Skin Diseases**

and

NYU Hospitals Center

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Research Registry for Neonatal Lupus

Information about the person filling out this questionnaire

Today's date:
What is your relationship to the child with Neonatal Lupus?:
<input type="checkbox"/> Biological Father

Demographics:

Name:		Date of birth:
Address:		
City:	State:	Zip:
Home phone:	Mobile phone:	E-mail address:

*(For all studies involving human subjects, Federal regulations (OMB Directive No. 15) require that we maintain, collect and present data on ethnicity **and** race for reporting the inclusion of women and minorities as subjects in research.*

Ethnic Categories:

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown (individuals not reporting ethnicity)

Racial Categories:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- More than one Race
- Unknown or Not Reported
- Decline

Medical History of the Neonatal Lupus Child's Father

Have you had daily, persistent, troublesome dry eyes for more than 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do your eyes often feel gritty or sandy?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do you use tear substitutes more than 3 times a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Have you had a daily feeling of dry mouth for more than 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
As an adult, have you had frequent or long-lasting mumps-like swelling on the side of your face? (Do not include childhood mumps)	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do you often drink liquids to help you swallow dry foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Have exposed parts of your body (including your face) ever broken out in a rash when you went out in the sun?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Within the last 5 years, have you had mouth ulcers (check all that apply): <input type="checkbox"/> on the inside of your cheeks? <input type="checkbox"/> on your gums? <input type="checkbox"/> No mouth ulcers <input type="checkbox"/> on your tongue? <input type="checkbox"/> on the roof of your mouth?															
Have you ever had nasal ulcers?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Do your fingertips change colors (for example, become white, blue, and then red) when exposed to the cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Have you ever been told by a doctor that you had fluid around your heart (pericarditis)?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No														
Have you ever been told by a doctor that you had fluid around your lung (pleuritis)?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No														
Have you ever experienced joint pain not as a result of injury? If yes, answer the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No														
<table border="0"> <thead> <tr> <th style="text-align: left;">Which joints?</th> <th style="text-align: left;">Date last happened</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Hands/wrist</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Elbow</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Hips</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Knee</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Ankle</td> <td>_____</td> </tr> </tbody> </table>		Which joints?	Date last happened	<input type="checkbox"/> Hands/wrist	_____	<input type="checkbox"/> Elbow	_____	<input type="checkbox"/> Shoulder	_____	<input type="checkbox"/> Hips	_____	<input type="checkbox"/> Knee	_____	<input type="checkbox"/> Ankle	_____
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Medical History of the Neonatal Lupus Child's Father (continued)

<p>Have any of your joints swelled not as a result of injury? If yes, answer the following:</p> <p>Which joints? Date last happened</p> <p><input type="checkbox"/> Hands/wrist _____</p> <p><input type="checkbox"/> Elbow _____</p> <p><input type="checkbox"/> Shoulder _____</p> <p><input type="checkbox"/> Hips _____</p> <p><input type="checkbox"/> Knee _____</p> <p><input type="checkbox"/> Ankle _____</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>Have any of your joints ever been red or felt hot not as a result of injury? If yes, answer the following:</p> <p>Which joints? Date last happened</p> <p><input type="checkbox"/> Hands/wrist _____</p> <p><input type="checkbox"/> Elbow _____</p> <p><input type="checkbox"/> Shoulder _____</p> <p><input type="checkbox"/> Hips _____</p> <p><input type="checkbox"/> Knee _____</p> <p><input type="checkbox"/> Ankle _____</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>Has a doctor ever told you that you had protein in your urine?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Have you ever had a seizure?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Have you ever had a stroke?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Has a doctor ever told you that you had a low white blood count?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Has a doctor ever told you that you had a low platelet count?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Have you ever had a lip biopsy done?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Has a doctor ever told you that you have Sjögren's Syndrome?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>
<p>Has a doctor ever told you that you have Systemic Lupus Erythematosus?</p>	<p><input type="checkbox"/> Yes When? _____</p> <p><input type="checkbox"/> No</p>

Medical History of the Neonatal Lupus Child's Father (continued)

Has a doctor ever told your that your have Rheumatoid Arthritis?	<input type="checkbox"/> Yes When? _____ <input type="checkbox"/> No
Please list any medical conditions for which you see a physician.	
What medications (if any) are you currently taking? Please specify dosage, if known.	

What is your blood type?	
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Information about Father's Current Physician

Name:		Specialty:
Address:		
City:	State:	Zip:
Phone:	Fax:	

This is the end of the questionnaire. THANK YOU for your participation.
Please use this room to add any additional comments
(Feel free to use the back of this page or enclose additional sheets):