Assessment of the Frequency of Diabetes-Related Chronic Kidney Disease in the Cappadocia Cohort

D A T A R E P O R T F O R M

CAPPADOCIA COHORT HOUSEHOLD NO: ……	SUBJECT ID: ……	INTERVIEWER NO:……

VISIT	
DATE: ..... / ..... / ..... Day Month Year	**TIME:** ..... / ..... Hour Minute
INITIALS OF THE SUBJECT'S NAME AND SURNAME:	
CONTACT INFORMATION	
CITY:	**NEIGHBORHOOD/DISTRICT/VILLAGE:** .....
NEIGHBORHOOD:	**STREET:** .....
BUILDING NO: ..... **BLOCK:**	**APARTMENT NO:** .....
Home Phone: ..... /	**Personal** ☐ **Other:** .....
Work Phone: ..... /	**Personal** ☐ **Other:** .....
Mobile Phone: ..... /	**Personal** ☐ **Other:** .....
Mobile Phone: ..... /	**Personal** ☐ **Other:** .....
Not want to provide a phone number ☐	
e-mail address: ……@.....	**Personal** ☐ **Other:** .....

DEMOGRAPHIC CHARACTERISTICS		
Age **.....**.....	**Gender** ☐ Male ☐ Female	**Date of birth** ..... / ..... / ..... Day Month Year

SUBJECT SELECTION CRITERIA

STUDY INCLUSION CRITERIA

	Yes	**No**
1. Those included in the Cappadocia Cohort,	☐	☐
2. Those aged 18 and above,	☐	☐
3. Those who were diagnosed with diabetes and receiving oral antidiabetic or insulin treatment for at least one year,	☐	☐
4. Those who were informed about the study and provided written consent,	☐	☐
5. Those who provided contact information and agreed to be contacted periodically.	☐	☐

All questions above must be answered **Y E S** for the subject to be included in the study!

STUDY EXCLUSION CRITERIA

	Yes	**No**
1. Pregnant subjects.	☐	☐
2. Those with active infections.	☐	☐
3. Those with active malignant diseases.	☐	☐
4.		
5.		

All answers above must be **N O** for the subject to be included in the study!

SOCIOECONOMIC CHARACTERISTICS				
1. Place of Birth	.....			
2. Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed
3. Do you have children?	☐ Yes	☐ No		
4. If yes, how many?	.....			
5. The most recently graduated school	☐ University ☐ High School	☐ Middle School ☐ Primary School	☐ Literate ☐ Illiterate	
6. Occupation	☐ Government Employee ☐ Worker ☐ Housewife	☐ Tradesperson ☐ Student ☐ Unemployed	☐ Self-employed ☐ Other	
7. Average Monthly Income	☐ None	☐ 1,000–2,500 TL	☐ > 10,000 TL	
	☐ < 500 TL	☐ 2,500- 5,000 TL		
	☐ 500–1,000 TL	☐ 5,000–10,000 TL		
8. Home internet access	☐ Yes	☐ No		
9. Do you use the internet?	☐ Yes	☐ No		

HABITS		
1. Alcohol consumption habit		
☐ I do not drink		
☐ I drink	☐ Low alcohol (Beer, wine, etc.)	☐ High alcohol (Raki, whiskey, etc.)
Quantity (per week)	..... Glasses for ..... years	..... Glasses for ..... years
2. Smoking Habit:		
☐ I have never smoked	☐ I quitted smoking ..... years ago I smoked..... years ..... cigarettes/day.	☐ I am a current smoker I have been smoking for.....years ..... cigarettes/day

DIABETES AND KIDNEY DISEASE HISTORY	
1. Has your blood glucose been measured by a doctor or another healthcare professional?	☐ Yes ☐ No
2. Has a doctor or healthcare professional informed you that you have high blood sugar or **Diabetes?**	☐ Yes ☐ No
3. Please state the date of your diabetes diagnosis:	..... / ..... **Month Year**
4. How often do you attend diabetes check-ups?	☐ Every two months ☐ Every three months ☐ Every four months ☐ Every six months ☐ Annually
5. What procedures are conducted during your diabetes check-ups? Multiple choices are allowed.	☐ Examination ☐ Blood Pressure Measurement ☐ Blood Glucose Measurement ☐ Three-Month Blood Glucose Average (HBA1C) ☐ Cholesterol Level Measurement ☐ Other Blood Tests ☐ Kidney Tests ☐ Urine Test ☐ Urinary Albumin Test
6. Which treatments have you used since being diagnosed with diabetes??	☐ Diet only ☐ Diet and Medications ☐ Diet, Medications, and Insulin ☐ Diet and Insulin
7. Are you taking medication for diabetes?	☐ Yes ☐ No
If you answered 'Yes' to the 7th question, please provide information about the medications or insulin you use. ***Fill in the "Daily Dose" field by also specifying how many times per day the medication* or insulin *is taken (e.g., 3*20 mg). In the "Duration of use" field, indicate how long the medication or insulin has been used. If possible, take photos of the medication* or insulin *packaging.***	
Upload here a photo of the medications **or insulin** used. Click here to upload file. (< 5MB)	
1-Medication **or Insulin** Name (Preferably state the generic name.)	
1-Daily Dose	
1-Time of use (Morning/Noon/Evening)	
1-Duration of use (Year/Month/Week)	
1-Type of use (Continuous/As Needed)	
2-Medication **or Insulin** Name (Preferably state the generic name.)	
2-Daily Dose	

DIABETES AND KIDNEY DISEASE HISTORY
2-Time of use (Morning/Noon/Evening) .....
2- Duration of use (Year/Month/Week) .....
2- Type of use (Continuous/As Needed) .....
3-Medication **or Insulin** Name (Preferably state the generic name.) .....
3-Daily Dose .....
3-Time of use (Morning/Noon/Evening) .....
3-Duration of use (Year/Month/Week) .....
3-Type of use (Continuous/As Needed) .....
4-Medication **or Insulin** Name (Preferably state the generic name.) .....
4-Daily Dose .....
4-Time of use (Morning/Noon/Evening) .....
4-Duration of use (Year/Month/Week) .....
4- Type of use (Continuous/As Needed) .....
5-Medication **or Insulin** Name (Preferably state the generic name.) .....
5-Daily Dose .....
5-Time of use (Morning/Noon/Evening) .....
5-Duration of use (Year/Month/Week) .....
5-Type of use (Continuous/As Needed) .....
6-Medication **or Insulin** Name (Preferably state the generic name.) .....
6-Daily Dose .....
6-Time of use (Morning/Noon/Evening) .....
6-Duration of use (Year/Month/Week) .....
6-Type of use (Continuous/As Needed) .....
7-Medication **or Insulin** Name (Preferably state the generic name.) .....
7-Daily Dose .....

DIABETES AND KIDNEY DISEASE HISTORY	
7-Time of use (Morning/Noon/Evening)	
7-Duration of use (Year/Month/Week)	
7- Type of use (Continuous/As Needed)	
8. Do you have a blood glucose monitoring device at home?	☐ Yes ☐ No
9. If you have a blood glucose monitoring device, what is its Brand and Model?	.....
10. How often do you check your blood glucose levels with a fingerstick?	☐ Twice a day ☐ Once a day ☐ Twice a week ☐ Once a week ☐ Once every two weeks ☐ Once a month ☐ Once a year ☐ Never
11. Can you tell me which of the organs that I tell you might be affected by diabetes? [You can tell multiple options.]	☐ Skin ☐ Brain ☐ Eyes ☐ Heart ☐ Lungs ☐ Liver ☐ Intestines ☐ Kidney ☐ Bladder ☐ Nerves ☐ Feet
12. Has diabetes caused any of the following diseases/complications in you?	☐ Cerebrovascular Disease (e.g., Stroke) ☐ Eye Disease ☐ Heart Disease ☐ Kidney Disease ☐ Neuropathy (Diseases in Nerves) ☐ Foot Ulcer ☐ Need for Hospitalization
13. Has a doctor or another healthcare professional told you that you have **Kidney Disease** or that you have had it in the past?	☐ Yes ☐ No
14. Is your kidney disease related to your diabetes?	☐ Yes ☐ No *("If 'No', please make sure to certainly answer the next question.")*
15. Is your kidney disease related to another condition?	☐ Yes ☐ No If "Yes," please specify? ……..
16. Do you know that diabetes cause kidney disease?	☐ Yes ☐ No
17. If you have kidney disease, do you know its degree/stage?	☐ Yes ☐ No If "Yes", please specify the degree/stage? ……..

PHYSICAL ACTIVITY

1. Describe your level of physical activity at work. (If you work from home, are currently on medical leave, or are a university student, please also answer this question.)

- ☐ **Very low** (Sitting at a computer or desk for most of the day.)
- ☐ **Low** (Work involving minimal physical activity; e.g., industrial work, sales, or office jobs)
- ☐ **Moderate** (Jobs involving cleaning tasks (e.g., kitchen work), postal delivery)
- ☐ **High** (Heavy industrial work, construction work, or farming.)

2. Describe your level of physical activity during your leisure time. If your activities vary between summer and winter, please provide an estimated average.

- ☐ **Very low:** I almost have no physical activity
- ☐ **Low:** I walk, I cycle non-strenuously, or I engage in gardening approximately once per week
- ☐ **Moderate:** I engage in activities such as walking, cycling, gardening at least once a week, or walking to work 10-30 minutes daily
- ☐ **Active:** I engage in strenuous walking, cycling, or sports activities more than once a week
- ☐ **Very active:** I engage in high-intensity activities multiple times per week

BLOOD PRESSURE MEASUREMENT PRE-CHECKS **The following substances should not be consumed within the last 30 minutes before taking a blood pressure measurement.**		
Have you smoked in the last 30 minutes?	☐ Yes	☐ No
Have you consumed caffeine (tea, coffee, cola) in the last 30 minutes?	☐ Yes	☐ No

1st BLOOD PRESSURE MEASUREMENT		
How will the blood pressure measurement be taken?	☐ Sitting	☐ Lying down (if necessary)
Which arm will be used for measurement?	☐ Right	☐ Left
Systolic: ..... **mmHg**	**Diastolic:** ..... **mmHg**	

2nd BLOOD PRESSURE MEASUREMENT	
Systolic: ..... **mmHg**	**Diastolic:** ..... **mmHg**

3rd BLOOD PRESSURE MEASUREMENT	
Systolic: ..... **mmHg**	**Diastolic:** ..... **mmHg**

AVERAGE BLOOD PRESSURE MEASUREMENT	
Systolic: ..... **mmHg**	**Diastolic:** ..... **mmHg**

PHYSICAL MEASUREMENTS (BODY COMPOSITION ANALYSIS)	
Height: **……..... cm**	**Lean Body Mass:** **……... kg**
Weight: **……..... cm**	**Body Mass Index:** **……... kg / m^2**

MEDICAL HISTORY	
1. Have you been told by a doctor or other healthcare professional that you have **High Blood Pressure (Hypertension)?**	☐ Yes ☐ No
2. If you were diagnosed with hypertension, when was the date?	..... / ..... / ..... **Day Month Year**
3. Do you take medication for your hypertension?	☐ Yes ☐ No
If you answered 'Yes' to the 3rd question, please provide information about the medications you use. ***Fill in the "Daily Dose" field by also specifying how many times per day the medication is taken (e.g., 3*20 mg). In the "Duration of use" field, indicate how long the medication has been used. If possible, take photos of the medication packaging.***	
Upload here a photo of the medications used. Click here to upload file. (< 5MB)	
1-Medication Name (Preferably state the generic name.)	
1-Daily Dose	
1-Time of use (Morning/Noon/Evening)	
1-Duration of use (Year/Month/Week)	
1-Type of use (Continuous/As needed):	
2-Medication Name (Preferably state the generic name.)	
2-Daily Dose	
2-Time of use (Morning/Noon/Evening)	
2-Duration of use (Year/Month/Week)	
2- Type of use (Continuous/As needed)	
3-Medication Name (Preferably state generic name.)	
3-Daily Dose	
3-Time of use (Morning/Noon/Evening)	
3-Duration of use (Year/Month/Week)	
3- Type of use (Continuous/As needed)	
4-Medication Name (Preferably state the generic name.)	
4-Daily Dose	
4-Time of use (Morning/Noon/Evening)	

MEDICAL HISTORY	
4-Duration of use (Year/Month/Week)	
4- Type of use (Continuous/As needed)	
5-Medication Name (Preferably state the generic name.)	
5-Daily Dose	
5-Time of use (Morning/Noon/Evening)	
5-Duration of use (Morning/Noon/Evening)	
5- Type of use (Continuous/As needed)	
4. Have you been told by a doctor or other healthcare professional that you have **Heart Disease?**	☐ Yes ☐ No
5. If you have been diagnosed with heart disease, when was it?	..... / ..... / ..... **Day Month Year**
6. Are you taking medication for your heart disease?	☐ Yes ☐ No
If you answered 'Yes' to the 6th question, please provide information about the medications you use. ***Fill in the "Daily Dose" field by also specifying how many times per day the medication is taken (e.g., 3*20 mg). In the "Duration of use" field, indicate how long the medication has been used. If possible, take photos of the medication packaging.***	
Upload here a photo of the medications used. Click here to upload file. (< 5MB)	
1-Medication Name (Preferably state the generic name.)	
1-Daily Dose	
1-Time of use (Morning/Noon/Evening)	
1-Duration of use (Year/Month/Week)	
1-Type of use (Continuous/As needed)	
2-Medication Name (Preferably state the generic name.)	
2-Daily Dose	
2-Time of use (Morning/Noon/Evening)	
2-Duration of use (Year/Month/Week)	
2-Type of use (Continuous/As needed)	
7. Have you been told by a doctor or other healthcare professional that you had a **stroke?**	☐ Yes ☐ No
8. If you have had a stroke, when was the date?	..... / ..... / ..... **Day Month Year**

MEDICAL HISTORY	
9. Do you take medication for your stroke disease?	☐ Yes ☐ No
If you answered 'Yes' to the 9th question, please provide information about the medications you use. ***Fill in the "Daily Dose" field by also specifying how many times per day the medication is taken (e.g., 3*20 mg). In the "Duration of use" field, indicate how long the medication has been used. If possible, take photos of the medication packaging.***	
Upload here a photo of the medications used. Click here to upload file. (< 5MB)	
1-Medication Name (Preferably state the generic name.)	
1-Daily Dose	
1-Time of use (Morning/Noon/Evening)	
1-Duration of use (Year/Month/Week)	
1-Type of use (Continuous/As needed)	
2-Medication Name (Preferably state the generic name.)	
2-Daily Dose	
2-Time of use (Morning/Noon/Evening)	
2-Duration of use (Year/Month/Week)	
2- Type of use (Continuous/As needed)	
10. Have you been told by a doctor or other healthcare professional that **diabetes affected your nerves** (you have neuropathy)?	☐ Yes ☐ No
11. If you have been diagnosed with neuropathy, when was the date?	..... / ..... / ..... **Day Month Year**
12.	
13.	
14. Do you take medication for your neuropathy?	☐ Yes ☐ No
If you answered 'Yes' to the 14th question, please provide information about the medications you use. ***Fill in the "Daily Dose" field by also specifying how many times per day the medication is taken (e.g., 3*20 mg). In the "Duration of use" field, indicate how long the medication has been used. If possible, take photos of the medication packaging.***	
Upload here a photo of the medications used. Click here to upload file. (< 5MB)	
1-Medication Name (Preferably state the generic name.)	
1-Daily Dose	
1-Time of use (Morning/Noon/Evening)	

MEDICAL HISTORY	
1-Duration of use (Year/Month/Week)	
1-Type of use (Continuous/As needed)	
2-Medication Name (Preferably state the generic name.)	
2-Daily Dose	
2-Time of use (Morning/Noon/Evening)	
2-Duration of use (Year/Month/Week)	
2-Type of use (Continuous/As needed)	
15. Have you been told by a doctor or other healthcare professional that you have **diabetic foot disease?**	☐ Yes ☐ No
16. If you have been diagnosed with diabetic foot disease, when was the date?	..... / ..... / ..... **Day Month Year**
17. Have you had a toe or foot or leg amputated because of your diabetic foot disease?	☐ Yes ☐ No
18. If you have had surgery because of your diabetic foot disease, when was the date?	..... / ..... / ..... **Day Month Year**
19. Are you taking medication for your diabetic foot disease?	☐ Yes ☐ No
If you answered 'Yes' to the 19th question, please provide information about the medications you use. ***Fill in the "Daily Dose" field by also specifying how many times per day the medication is taken (e.g., 3*20 mg). In the "Duration of use" field, indicate how long the medication has been used. If possible, take photos of the medication packaging.***	
Upload here a photo of the medications used. Click here to upload file. (< 5MB)	
1-Medication Name (Preferably state the generic name.)	
1-Daily Dose	
1-Time of use (Morning/Noon/Evening)	
1-Duration of use (Year/Month/Week)	
1-Type of use (Continuous/As needed)	
2-Medication Name (Preferably state the generic name.)	
2-Daily Dose	
2-Time of use (Morning/Noon/Evening)	
2-Duration of use (Year/Month/Week)	
2-Type of use (Continuous/As needed)	

	FAMILY MEDICAL HISTORY						
	Please indicate if your mother, father, grandfather, grandmother or siblings has hypertension or kidney disease (Please indicate siblings as male (M), female (F) for full siblings, or with lower case letters (m/f) if only the mother or father is common). (If the exact ages are not known, approximate ages such as 55, 30 can be written.)						
	Diabetes	Hypertension	Kidney Disease	Cause of Death			
				Heart Disease	Stroke	Being A Dialysis Patient	Age at Death
Mother	☐	☐	☐	☐	☐	☐	.....
Father	☐	☐	☐	☐	☐	☐	.....
Maternal Grandmother	☐	☐	☐	☐	☐	☐	.....
Paternal Grandmother	☐	☐	☐	☐	☐	☐	.....
Paternal Grandfather	☐	☐	☐	☐	☐	☐	.....
Maternal Grandfather	☐	☐	☐	☐	☐	☐	.....
Siblings ❑ M ❑ F ❑ m ❑ f	☐	☐	☐	☐	☐	☐	.....
❑ M ❑ F ❑ m ❑ f	☐	☐	☐	☐	☐	☐	.....
❑ M ❑ F ❑ m ❑ f	☐	☐	☐	☐	☐	☐	.....
❑ M ❑ F ❑ m ❑ f	☐	☐	☐	☐	☐	☐	.....

QUESTIONS RELATED TO URINE	
1. Do you urinate (peeing) frequently throughout the day?	☐Yes ☐No
2. How often do you urinate throughout the day?	☐ Less than once every 6 hours ☐ Every 5-6 hours ☐ Every 3-4 hours ☐ Every 1-2 hours ☐ More than once an hour
3. Do you wake up during the night to urinate? If so, how many times?	☐No ☐1 ☐2 ☐3 ☐4 ☐5 and more
4. Do you experience pain, burning, or discomfort while urinating?	☐Yes ☐No
5. Do you experience an uncontrollable urge to urinate suddenly?	☐Yes ☐No
6. Do you experience urinary leakage?	☐Yes ☐No

URINE COLLECTION	
Please indicate whether the subject accepts to collect their first morning urine for 3 days and explain the following details to the subject:	
The Subject **Accepted Urine collection** ☐ **Did not accept Urine collection** ☐ **Reason :**	
You are REQUIRED TO COLLECT your *first morning urine* for 3 days (either consecutively or on separate days)! Please urinate into the SPECIAL URINE COLLECTION CONTAINER that we will provide to you and hand it over to the field team that will visit you again. In the meantime, please store your urine in your refrigerator at 2-8°C.	
☐ **The Urine Collection Container Have Been Provided.**	**Date of Receipt:** ..... / ..... / ..... **Day Month Year**
☐ **The Urine Collection Container Could Not Be Provided.**	**Reason:** ....

SECOND VISIT	
☐ **The Urine Collection Container Has Been Received**	**Date:** ..... / ..... / ..... **Day Month Year**
☐ **The Urine Collection Container Could Not Be Received.**	**Reason:** .....
☐ **Blood Was Drawn From The Subject**	**Date:** ..... / ..... / ..... **Day Month Year**
☐ **Blood Could Not Be Drawn From The Subject**	**Reason:** .....
☐ **Urine and Blood Samples Were Delivered To The Laboratory**	**Date of Delivery:** ..... / ..... / ..... **Day Month Year**

*** Please attach the blood and urine laboratory results to the back of this form.**