

ID:

What is your current resting pulse rate (take after sitting for 5 minutes):

- Unsure
 <55/min
 55–59
 60–64
 65–69
 70–74
 75–79
 80–84
 85–89
 90–99
 ≥100

Since April 2012, have you been clinically diagnosed with anemia (Mark all that apply)?

- Yes
 No
- What was the anemia due to:
 Iron deficiency
 B12/folic acid deficiency
 Bleeding from heavy menstruation
 Bleeding from trauma
 Other
 Don't Know

Please, mark each treatment you received at the time of diagnosis.

- Iron supplements
 Vitamin supplement containing folate/B12
 Blood transfusion
 Other (e.g., Herbal medicine)
 No treatment

Do you currently smoke cigarettes?

- Yes
 No
- How many per day?
 1–4
 5–14
 15–24
 25–34
 35–44
 45+

Section II. Family Health

Now we are going to ask some QUESTIONS ABOUT YOUR FAMILY MEMBERS. If you are unsure about an answer, please provide your best estimate.

Has the biological father of your first GDM pregnancy been diagnosed with any of these conditions since April 2012?

Mark if biological father unknown

- Type 2 diabetes
 Type 1 diabetes
 High blood pressure
 Elevated cholesterol
 Heart disease

	Since April 2012		
	Yes	No	Don't Know
Type 2 diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type 1 diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have any of your family members been told by a clinician that they have/had any of the following?

Chronic kidney disease:
 Mother
 Father
 Sibling
 None
 Don't know

Diabetic retinopathy (trouble with eyesight due to their diabetes):
 Mother
 Father
 Sibling
 None
 Don't know

Please complete one column of the chart for each of your biological children.
 I do not have biological children.

Please complete the following section for all your biological children	1 st born (oldest child)	2 nd born	3 rd born	4 th born
Child's current age:	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Child's current height:	<input type="text"/> ft <input type="text"/> <input type="text"/> in	<input type="text"/> ft <input type="text"/> <input type="text"/> in	<input type="text"/> ft <input type="text"/> <input type="text"/> in	<input type="text"/> ft <input type="text"/> <input type="text"/> in
Child's current weight:	<input type="text"/> <input type="text"/> <input type="text"/> lbs	<input type="text"/> <input type="text"/> <input type="text"/> lbs	<input type="text"/> <input type="text"/> <input type="text"/> lbs	<input type="text"/> <input type="text"/> <input type="text"/> lbs
Has a doctor ever diagnosed your child(ren) with any of the following conditions? (mark <u>all</u> that apply)	<input type="radio"/> Kidney diseases <input type="radio"/> Myopia/ shortsightedness <input type="radio"/> PCOS (polycystic ovary syndrome) <input type="radio"/> None of the above <input type="radio"/> Child passed away	<input type="radio"/> Kidney diseases <input type="radio"/> Myopia/ shortsightedness <input type="radio"/> PCOS (polycystic ovary syndrome) <input type="radio"/> None of the above <input type="radio"/> Child passed away	<input type="radio"/> Kidney diseases <input type="radio"/> Myopia/ shortsightedness <input type="radio"/> PCOS (polycystic ovary syndrome) <input type="radio"/> None of the above <input type="radio"/> Child passed away	<input type="radio"/> Kidney diseases <input type="radio"/> Myopia/ shortsightedness <input type="radio"/> PCOS (polycystic ovary syndrome) <input type="radio"/> None of the above <input type="radio"/> Child passed away
Since April 2012, has a doctor ever diagnosed your child(ren) with any of the following conditions? (mark <u>all</u> that apply)	<input type="radio"/> Type 2 diabetes <input type="radio"/> Type 1 diabetes <input type="radio"/> High blood pressure <input type="radio"/> High cholesterol <input type="radio"/> Asthma <input type="radio"/> Schizophrenia <input type="radio"/> Multiple sclerosis <input type="radio"/> Autism, Aspergers or another autism spectrum disorder <input type="radio"/> None of the above	<input type="radio"/> Type 2 diabetes <input type="radio"/> Type 1 diabetes <input type="radio"/> High blood pressure <input type="radio"/> High cholesterol <input type="radio"/> Asthma <input type="radio"/> Schizophrenia <input type="radio"/> Multiple sclerosis <input type="radio"/> Autism, Aspergers or another autism spectrum disorder <input type="radio"/> None of the above	<input type="radio"/> Type 2 diabetes <input type="radio"/> Type 1 diabetes <input type="radio"/> High blood pressure <input type="radio"/> High cholesterol <input type="radio"/> Asthma <input type="radio"/> Schizophrenia <input type="radio"/> Multiple sclerosis <input type="radio"/> Autism, Aspergers or another autism spectrum disorder <input type="radio"/> None of the above	<input type="radio"/> Type 2 diabetes <input type="radio"/> Type 1 diabetes <input type="radio"/> High blood pressure <input type="radio"/> High cholesterol <input type="radio"/> Asthma <input type="radio"/> Schizophrenia <input type="radio"/> Multiple sclerosis <input type="radio"/> Autism, Aspergers or another autism spectrum disorder <input type="radio"/> None of the above

Mark here if you have had >4 children and please download and print form from www.dwhstudy.org/forms.