

Site Number: _____ Screening ID: _____ - _____

Participant Letters: _____

Collect information for this form during Screening or Baseline visits. Study personnel should complete this form.

A. FAMILY HISTORY INFORMATION

- How many of your first and second degree relatives have **type 1 diabetes** (including deceased relatives)?
- Have any of your first and second degree relatives been diagnosed with an autoimmune (AI) disease **other than** type 1 diabetes?

Y N

Use the codes in the following two tables to answer questions 3 and 5 in the table below.

Use the letter codes below to indicate the type of relative (question 3):

P Parent	GP Grandparent	AU Aunt/Uncle	HC Half-Cousin
IT Identical Twin	NT Non-identical Twin	N Niece/Nephew	CH Child
FS Brother/Sister	HS Half Brother/Sister	C Cousin	

Use the number codes below to indicate the type of Autoimmune (AI) Disease (question 5):

01 Addison's Disease (Adrenal Insufficiency)	09 Hypoparathyroidism
02 Alopecia	10 Pernicious Anemia
03 Celiac Disease (Gluten Allergy or Celiac Sprue)	11 Vitiligo
04 Grave's Disease (Hyperthyroidism)	12 Psoriasis
05 Immune Thyroid Disease	13 Lupus
06 Rheumatologic Disease	14 Multiple Sclerosis
07 Inflammatory Bowel Disease	99 Other Autoimmune Disease
08 Hypogonadism or Premature Menopause	

3. Relative with Type 1 Diabetes or Other AI Disease	4. Does Relative have Type 1 Diabetes?	5. Type of Autoimmune Disease	6. Sex of Relative	7. Age at Diagnosis	8. If Half Sibling , Indicate Same Mother or Same Father
<i>Code Above</i>	<i>Code Above</i>	<i>Code Above</i>	<i>In Years</i>	<i>Choose One</i>	
e.g. P _____	<input checked="" type="radio"/> Y <input type="radio"/> N	1) 02 2) _____	<input checked="" type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	63	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
a. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
b. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
c. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
d. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
e. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
f. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father
g. _____	Y N	1) _____ 2) _____	<input type="checkbox"/> ₁ Male <input type="checkbox"/> ₂	_____	<input type="checkbox"/> ₁ Same Mother <input type="checkbox"/> ₂ Same Father

Initials (first, middle, last) of person completing this form:

F M L

Date form completed:

____ / ____ / ____
DAY MONTH YEAR

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates.
Write "*" if the desired information is permanently unavailable (i.e. will not be known in any future updates).



CTLA-4 Ig Study
FAMILY HISTORY FORM

Form CTL04

01 JAN 2008

Version 1.0

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Top Copy – Send to TrialNet Coordinating Center

Bottom Copy – Retain at site