Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ Participant Letters: __ __ __

Complete this form during the Screening Visit.

A. VISIT INFORMATION

1. Date Screening Visit Completed (*e.g. 05/Feb/2008*): __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
2. Did visit occur at a site other than the primary study site? Y N
   If YES,
   a. Record Site Number for reimbursement: __ __ __ __

***NOTE**: Site Number **must** correspond to a TrialNet Clinical Center, Affiliate, or Participating Physician*

B. INFORMED CONSENT

1. Date written informed consent for *screening* obtained: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
2. On the *screening* consent form, was permission given for DNA samples to be stored? Y N
3. On the *screening* consent form, was permission given for *non*-DNA samples to be stored? Y N

C. DEMOGRAPHIC INFORMATION

1. Date of birth: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
2. Age (years): __ __
3. Sex: ☐ 1 Male ☐ 2 Female
4. Ethnicity *(check one):*
   ☐ 1 Hispanic or Latino ☐ 2 Not Hispanic or Latino
5. Race *(check all that apply):*
   a. ☐ 1 American Indian or Alaskan Native
   b. ☐ 1 Asian
   c. ☐ 1 Black or African American
   d. ☐ 1 Native Hawaiian or Other Pacific Islander
   e. ☐ 1 White
   f. ☐ 1 Other

   If OTHER, 1) Specify: _____

   2) Record the 3-digit code for race/ethnicity *(International sites only)*: a) ___ ___ ___ b) ___ ___ ___ c) ___ ___ ___
6. How did the participant first hear about this study *(check one)*?
   ☐ 1 Health Care Provider ☐ 3 Family/Friend ☐ 5 Radio/TV ☐ 7 Magazine
   ☐ 2 Meeting/Presentation ☐ 4 Poster ☐ 6 Internet ☐ 8 Other

   If OTHER, a. Specify: _____

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).*

D. MEDICATIONS OTHER THAN INSULIN

1. Are you currently taking any other prescription medication(s), non-prescription medication(s), or supplements other than insulin? Y N

   If YES, list medications/supplements:

   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____
   g. _____
   h. _____
   i. _____
   j. _____

2. Are any of these medications steroids? *(Steroid use is an exclusion criterion for this study)* Y N

   a. If YES, specify: _____

E. REVIEW OF SYSTEMS

1. Record whether there are any abnormalities in the following systems review

	1) Normal?	If ABNORMAL, a) Explain:
a. HEENT	Y N	_____
b. Pulmonary	Y N	_____
c. Cardiovascular	Y N	_____
d. Endocrine (other than T1D)	Y N	_____
e. Gastrointestinal	Y N	_____
f. Reproductive	Y N	_____
g. Musculoskeletal	Y N	_____
h. Neurological	Y N	_____
i. Integument	Y N	_____

2. Are there any additional abnormalities not already indicated above? Y N

   a. If YES, describe: _____

F. PHYSICAL EXAM

1. Collect the following physical assessments:

   a. Weight: __ __ __.__ kg or __ __ __. __ __ lbs

   b. Height: __ __ __.__ cm or __ __. __ __ in

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F. PHYSICAL EXAM (Continued)

c. Seated arm blood pressure:
Note: *Have the participant rest for 5 minutes before assessment.*

__ __ __ mmHg / __ __ __ mmHg
Systolic Diastolic

2. Indicate the participant's sexual development using the Tanner Scale:
(Complete question for participants 17 years of age or younger)

Tanner Stage	*Check One*		
a. Breast **(female)**	☐ 1 Stage 1	☐ 2 Stage 2	☐ 3 Stage 3 or greater
b. Genitalia **(male)**	☐ 1 Stage 1	☐ 2 Stage 2	☐ 3 Stage 3 or greater
c. Pubic Hair **(both)**	☐ 1 Stage 1	☐ 2 Stage 2	☐ 3 Stage 3 or greater

3. Were there any abnormalities on the physical exam? Y N
If YES,
a. Specify: _____

4. Was a urine pregnancy test completed at this visit? Y N
If YES,
a. Was the test result positive? Y N

If the **pregnancy test** result was **positive**, **STOP HERE**, DO NOT perform the MMTT, DO NOT complete this form, and DO NOT send this form to The Coordinating Center.

G. SPECIMENS

The following specimens should be drawn during this visit:

	Collected on this visit date?	**a. If NO, date sample collected**
1. CBC with Differential *(analysis done at local lab)*	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
2. Chemistries	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
3. EBV/CMV Serology	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
4. HIV, Hep B and C	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
5. Serum for Autoantibodies	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
6. 4-hour MMTT	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
7. PPD Test	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
8. EBV PCR	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
9. PBMC/plasma	Y N	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR

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).*

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