Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ Participant Letters: ___ ___ ___

A. VISIT INFORMATION

1. Date Initial Visit completed (*e.g. 10/Sep/2015*): * __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

B. INFORMED CONSENT

1. Date written informed consent/assent obtained: * __ __ / __ __ __ / __ __ __ __ (Day / Month / Year)

2. On the consent form, did the participant/participant's legal guardian consent to continued storage of residual blood samples in the NIDDK Repository after TrialNet has ended? * ☐Yes ☐No

3. Was the Volunteer Understanding Assessment Completed?* ☐Yes ☐No

C. MEDICAL HISTORY

1. Autoimmune Disease History
   a. Has the participant ever been diagnosed with an autoimmune disease(s)? * ○ Yes ○ No ○ Unknown

If YES,		Date of diagnosis
Addison's Disease (Adrenal Insufficiency)	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Alopecia	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Celiac Disease (Gluten Allergy or Celiac Sprue)	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Grave's Disease (Hyperthyroidism)	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Hypogonadism or Premature Menopause	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Hypoparathyroidism	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Autoimmune Thyroid Disease (Hypothyroidism or Hashimoto's Disease)	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Inflammatory Bowel Disease	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Lupus	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Multiple Sclerosis	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Pernicious Anemia	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Psoriasis	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Rheumatologic Disease	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Vitiligo	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
Other, specify:_____	○ Yes ○ No	__ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

2. Antibiotic Use
Has the participant used antibiotics in the past 3 months* ○ Yes ○ No ○ Unknown

D. FAMILY HISTORY

1. Have any of the participant's first or second degree relatives been diagnosed with Type 1 Diabetes (T1D) since the completion of the **Natural History Family History Form (NH01F)?*** Y N

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2. Relative with Type 1 Diabetes	3. Sex of Relative	4. Current Age of Relative	5. Age of T1D Onset in Relative	6. Age Relative Started Insulin	Comments
Select One	**CHECK ONE**	**Age in Years**	**Age in Years**	**Age in Years**	*Comments*
a. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____
b. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____
c. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____
d. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____
e. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____
f. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____
g. ___ ___	☐1 Male ☐2 Female	___ ___	___ ___	___ ___	_____

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

7. Autoimmune Disease History
Has anyone in the participant's family (first or second degree relatives only) ever been diagnosed with an autoimmune disease(s)? * ○ Yes ○ No ○ Unknown

If YES,
Addison's Disease (Adrenal Insufficiency) ○ Yes ○ No

Date of diagnosis
__ __ / __ __ __ / __ __ __ __
DAY MONTH YEAR

Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ Participant Letters: ___ ___ ___

Alopecia	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Celiac Disease (Gluten Allergy or Celiac Sprue)	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Grave's Disease (Hyperthyroidism)	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Hypogonadism or Premature Menopause	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Hypoparathyroidism	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Autoimmune Thyroid Disease (Hypothyroidism or Hashimoto's Disease)	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Inflammatory Bowel Disease	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Lupus	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Multiple Sclerosis	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Pernicious Anemia	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Psoriasis	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Rheumatologic Disease	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Vitiligo	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR
Other, specify:_____	O Yes O No	__ __ / __ __ __ / __ __ __ __ DAY MONTH YEAR

E. PREGNANCY MONITORING

1. Does the participant have reproductive or childbearing potential? * O Y O N

If YES,

a. Was a urine pregnancy test completed at this visit? * O Y O N

If YES,

1) Was the test result positive? * O Y O N

F. GENERAL PHYSICAL EXAM

1. Seated arm blood pressure: * ___ ___ ___ mmHg (Systolic) / ___ ___ ___ mmHg (Diastolic) □ not done

2. Weight: * ___ ___ ___.___ kg □ not done

3. Height: * ___ ___ ___.___ cm □ not done

a. Was a physical exam performed at this visit? * O Yes O No

Site Number: ___ ___ ___ ___ Participant ID: __ __ __ __ __ __ Participant Letters: __ __ __

	Findings	If ABNORMAL, explain:
a. HEENT*	○ Normal ○ Abnormal ○ Not Assessed	_____
b. Neck/Thyroid*	○ Normal ○ Abnormal ○ Not Assessed	_____
c. Heart*	○ Normal ○ Abnormal ○ Not Assessed	_____
d. Lungs*	○ Normal ○ Abnormal ○ Not Assessed	_____
e. Pulses*	○ Normal ○ Abnormal ○ Not Assessed	_____
f. Musculoskeletal*	○ Normal ○ Abnormal ○ Not Assessed	_____
g. Genitalia*	○ Normal ○ Abnormal ○ Not Assessed	_____
h. Abdomen*	○ Normal ○ Abnormal ○ Not Assessed	_____
i. Lymphatics*	○ Normal ○ Abnormal ○ Not Assessed	_____
j. Skin*	○ Normal ○ Abnormal ○ Not Assessed	_____
k. Neurologic*	○ Normal ○ Abnormal ○ Not Assessed	_____
l. Other*	○ Abnormal ○ Not Assessed	_____

G. TEST RESULTS

1. Random fingerstick glucose (per clinic meter): * __ __ __.__ mg/dl □ not done