Diabetes Prevention Program

SCREENING STEP 3 INVENTORY - START

This form is completed during the Start-visit of Screening Step 3.
Form S05 records the following: history on family, weight, smoking, aspirin use, cardiovascular and stroke/TIA, other diseases/symptoms, diet, and medical history for women; anthropometric and ankle/arm systolic blood pressure; dispensing of medication for run-in.

Part I / IDENTIFICATION

A. Participant Identification

1. Clinic number [ ][ ] CLINIC
2. Screening number [S][ ][ ][ ][ ][ ] SCREEN
3. Participant's initials [ ][ ][ ][ ] INITS (first last)
4. Participant's date of birth [ ][ ] / [ ][ ] / [ ][ ] DOB (month day year)
5. Participant's sex Male [1] Female [2] SEX

B. Visit Information

1. Date of visit [ ][ ] / [ ][ ] / [ ][ ] SIVSTDT (month day year)

C. Instructions for Form S05 Completion

Complete all sections of Form S05, unless an EXCLUSION is encountered in section I, J or Q.

Initials of person reviewing completed form [ ][ ][ ][ ] (first last) Form entered in computer? [ ]

Part II / PARTICIPANT HISTORY

D. Family Information

		Mother	Father
1. Did your mother or father have diabetes?	SIMDIAB / SIFDIA	YES 1 NO 2 Don't Know 3	YES 1 NO 2 Don't Know 3
a. If YES, age at diagnosis	SIMDAGE / SIFDAGE	___ years	___ years
2. Did your mother or father ever have a heart attack?	SIMMI / SIFMI	YES 1 NO 2 Don't Know 3	YES 1 NO 2 Don't Know 3
a. If YES, age at first heart attack	SIMMIAG / SIFMIAG	___ years	___ years
3. What are your parents' **years** of birth	SIMYOB / SIFYOB	1___ Year	1___ Year
4. Are your parents still alive?	SIMALV / SIFALV	Alive 1 Dead 2	Alive 1 Dead 2
a. If dead, **year** of death	SIMYOD / SIFYOD	19__ Year	19__ Year

5. How many natural brothers and sisters do you have (include all living and deceased). SISIBS

6. How many of your brothers and sisters have or had diabetes? SISIBDI

7. How many of your brothers and sisters have had a heart attack? SISIBMI

E. Personal Weight History

1. Is your current weight different than it was one year ago? By different, I mean gaining or losing more than 5 pounds.

check only one

[1] No

[2] Yes, gained

a. How many pounds have you gained? ___ pounds SIWGTGN

b. Did you try to gain this weight? YES [1] NO [2] SITRYGN

SIWGTDF

[3] Yes, lost

c. How many pounds have you lost? ___ pounds SIWGTLS

d. Did you try to lose this weight? YES [1] NO [2] SITRYLS

[4] Don't know

2. What did you weigh when you were 20 years old *(Probe: weight before pregnancy, what is your best estimate*): ___ pounds SIWGT20

3. What is the most you have weighed as an adult (age 20 or after) *(Probe: do not include the times you were pregnant):* ___ pounds SIMAXWT

4. What is the least you have weighed as an adult (age 20 or after) : ___ pounds SILSTWT

5. How many times in your life have you lost at least 10 pounds and then gained it back (don't count the weight lost after pregnancy). ___ times SI10LBS

6. Have ever tried to lose weight? YES [1] NO [2] SILSWGT

If YES,
Have you tried this by: (*check all that apply*)

SIWDIET a. Dieting alone. . . . . [1]

SIWEXE b. Self-directed exercise. . . . . [1]

SIWCOMB c. Dieting and exercise combined. . [1]

SIWFEEXE d. Formal exercise program. . . . . [1]

e. Medication. . . . . [1] SIWMED

f. Surgery. . . . . [1] SIWSYRG

g. Formal weight loss program. [1] SIWFWL

F. Smoking History

	YES	NO	
1. Have you smoked more than 100 cigarettes in your lifetime?	[1]	[2]	SI100CG

If YES,

a. What is your current smoking status:

Current smoker [1]
Former smoker [2] SISMOK

If Former Smoker,

i. How old were you when you most recently stopped smoking? [ ][ ] age quit SIQOM

b. How old were you when you started smoking cigarettes? [ ][ ] years SISTRT

c. On average, how many cigarettes per day do you smoke or did you smoke? [ ][ ][ ] SICIGDY cigarettes/day

	YES	NO	
2. Do you currently smoke cigars?	[1]	[2]	SISGR

If YES,

a. How old were you when you started smoking cigars? [ ][ ] age started SISGRST

b. On average, how many cigars per week do you smoke? [ ][ ] cigars/week SISGRWK

	YES	NO	
3. Do you currently smoke a pipe?	[1]	[2]	SIPIPE

If YES,

a. How old were you when you started smoking a pipe? [ ][ ] age started SIPIPST

b. On average, how many pipefuls do you smoke per week? [ ][ ][ ] pipes/week SIPIPWK

G. Aspirin History

1. During an average week, how often do you take one or more aspirin tablets?

Never [1]
Less than 1 day per week [2]
1 or 2 days per week [3] SIASPIR
3 to 4 days per week (includes every other day) [4]
5 or 6 days per week [5]
Every day [6]

H. Thinking about the past 12 months please answer the following questions:

	YES	NO	
1. Have you had any pain or discomfort in your chest?	1	2	SIPAIN
2. Have you had any pressure or heaviness in your chest?	1	2	SIPRES

If Questions 1 AND 2 are NO, skip to Section I
If either are YES, continue

	YES	NO	
a. Do you get it when you walk uphill or hurry?	1	2	SIHURRY
b. Do you get it when you walk at an ordinary pace on the level?	1	2	SILEVEL

c. When you get it in your chest, what do you do?

Stop 1
Slow down 2 SIDO
Continue at same pace 3

	YES	NO	
d. Does it go away when you stand still?	1	2	SISTILL

If YES,

i. How Soon?

10 min. or less 1
more than 10 min. 2 SISOON

	YES	NO	
e. Where do you get this pain or discomfort:			
i. Sternum (central chest)?	1	2	SISTER
ii. Left anterior chest?	1	2	SILCHST
iii. Left arm?	1	2	SILARM

	YES	NO	
f. Have you ever had a severe pain across the front of your chest lasting for half an hour or more?	1	2	SI30MIN

I. Cardiovascular History

1. Has a doctor ever told you that you had a myocardial infarction or heart attack? YES [1] NO [2] SIMI

   If YES,

   a. When was your first heart attack: (month day year) SIMIFST

   Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

   b. When was your last heart attack: (month day year) SIMILST

   Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

   c. Hospital? _____

   d. Doctor? _____

2. Have you ever had coronary artery bypass surgery (graft, CABG)? YES [1] NO [2] SIBABG

   If YES,

   a. When was your first surgery: (month day year) SICBFST

   Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

   b. When was your last surgery: (month day year) SICBLST

   Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

   c. Hospital? _____

   d. Doctor? _____

3. Have you ever had an angioplasty of the coronary arteries, which is an opening of a blocked artery with a plastic tube in the blood vessel? YES [1] NO [2] SIBLLN

If YES,

a. When was your first angioplasty: month day year SIBLFST

Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

b. When was your last angioplasty: month day year SIBLLST

Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

c. Hospital? _____

d. Doctor? _____

4. Have you ever had a carotid endarterectomy or any other procedure to open up the blood vessels in your neck? YES [1] NO [2] SINECK

If YES,

a. When was your first surgery: month day year SINKFST

Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

b. When was your last surgery: month day year SINKLST

Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.a

c. Hospital? _____

d. Doctor? _____

5. Have you ever had bypass surgery of the lower extremities, to bypass a blocked artery in the leg?

YES [1] NO [2] SIBYLFG

If YES,

a. When was your first procedure: [ ][ ] [ ][ ] [ ][ ] (month day year) SIBYFST

b. When was your last procedure: [ ][ ] [ ][ ] [ ][ ] (month day year) SIBYLST

c. Hospital? _____

d. Doctor? _____

J. Stroke / TIA History

1. During the past 12 months, have you had any sudden feeling of numbness, tingling, or loss of feeling in either arm, hand, leg, foot, or face? YES [1] NO [2] SINUMB

If YES,

a. How long did the symptoms last?

< 1 hour [1]
1 - 24 hour(s) [2] SINUMBT
> 24 hours [3]

2. During the past 12 months, have you had any sudden attacks of paralysis, or loss of use of either arm, hand, leg, or foot? YES [1] NO [2] SIPARL

If YES,

a. How long did the symptoms last?

< 1 hour [1]
1 - 24 hour(s) [2] SIPARLT
> 24 hours [3]

3. During the past 12 months, have you had any sudden loss of eyesight or blurring of vision for a short period of time? YES [1] NO [2] SIBLUR

If YES,

a. How long did the symptoms last?

< 1 hour [1]
1 - 24 hour(s) [2] SIBLURT
> 24 hours [3]

4. During the past 12 months, have you had any sudden attacks of changes in speech, loss of speech or inability to say words for more than two minutes? YES [1] NO [2] SISLUR

If YES,

a. How long did the symptoms last?

< 1 hour [1]
1 - 24 hour(s) [2] SISLURT
> 24 hours [3]

5. During the past 12 months, have you had any spells or dizziness, difficulty in walking, lightheadedness or loss of balance? YES [1] NO [2] SIDIZY

6. Has a doctor ever told you that you had a stroke, mini-stroke or TIA (transient ischemic attack)?

No [1]
Yes, stroke [2] SISTRK
Yes, ministroke or TIA [3]
Yes, uncertain which [4]

If YES,

a. When was your first stroke: [ ][ ] [ ][ ] [ ][ ] (month day year) SISKFST

Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.f

b. When was your last stroke: [ ][ ] [ ][ ] [ ][ ] (month day year) SISKLST

Exclude if within the past 6 months. Fill out Eligibility Checklist item D.3.f

c. Hospital? _____

d. Doctor? _____

K. Has a doctor told you that you had any of the following?

		Ever		Past 12 months		
		YES	NO	YES	NO	
1.	High blood pressure (hypertension)? SIHYPE1	1	2	1	2	SIHYPE1
2.	Angina? SIANGI1	1	2	1	2	SIANGI2
3.	High cholesterol (high blood fats)? SILIPI1	1	2	1	2	SILIPI2
4.	Ulcer (stomach or duodenal), or intestinal bleeding? SIULCR1	1	2	1	2	SIULCR2
5.	Hepatitis? SIHEP1	1	2	1	2	SIHEP2
6.	Cancer? SICNCR1	1	2	1	2	SICNCR2
7.	Gallstones, gallbladder disease, or gallbladder surgery? SIGALL1	1	2	1	2	SIGALL2
8.	Gout? SIGOUT	1	2	1	2	SIGOUT2
9.	Thyroid disease? SITHYR1	1	2	1	2	SITHYR2
10.	Other major diseases? SIOTH1	1	2	1	2	SIOTH2

a. If YES, specify _____

L. During the past 12 months have you experienced any of the following?

		YES	NO	
1.	Skin rashes?	1	2	SIRASH
2.	Frequent stomach pains, bloating, nausea, diarrhea, or loss of appetite?	1	2	SISTOM
3.	Unexplained weight loss?	1	2	SILOSEW
4.	Increased thirst (drinking more liquids than usual)?	1	2	SITHRST
5.	Urinating more often than usual?	1	2	SIURINT

M. Diet

		YES	NO	
1.	Are you now on a special diet for any reason?	1	2	SISPECD

If YES,
Specify (check all that apply)

a. Low cholesterol or low fat (for high cholesterol) 1 SILOWFT

b. Low salt (for high blood pressure) 1 SILOWNA

c. Low calorie (for weight loss) 1 SILOWCA

d. Vegetarian 1 SIVEGE

e. Other diet (specify: _____) 1 SIOTHD

If FEMALE, continue
If MALE, skip to Section O - Anthropometrics

N. Medical History Questionnaire for Women

1. Are you still having periods (menstrual bleeding)?

No [1] SIMENS
Yes [2]
Uncertain [3]
Never had a period [4]

If NO or UNCERTAIN

a. How long ago was your last period?

< 6 months [1]
6 - 12 months [2] SIMENST
13 - 24 months (1 - 2 years) [3]
25 or more months (more than 2 years) [4]

If 13 or more months

i. At what age was your last period? [ ][ ] years SIMENSA

2. Are you currently having hot flashes or night sweats? YES [1] NO [2] SIHOTFL

If YES,

a. What was your age when you first had symptoms? [ ][ ] years SIHOTAG

3. During most of your life, were your periods regular? That is, did they occur about once a month? (Do not include any time when you were pregnant or taking birth control pills).

No [1]
Yes [2] SIMREG
Sometimes regular, sometimes irregular [3]

4. Between the time you had your first and last period, did you ever go without any periods for at least one year? (Do not count times you were pregnant or breast-feeding). YES [1] NO [2] SI1YR

If YES,

a. What is the longest interval? (Not counting pregnancy and breast-feeding).

12 - 23 months [1]
24 - 48 months [2] SI1YRT
more than 48 months (4 years) [3]

		YES	NO	
5.	Have you ever been pregnant?	1	2	SIPRGEV
	If YES,			
	a. How many times have you been pregnant?	[ ][ ] times		SIXPEG
	b. How many live births have you had?	[ ][ ] live births		SIBIRTH
	c. How many stillbirths, miscarriages, and abortions have you had?	[ ][ ] total number		SIABORT

		YES	NO	
6.	Have you ever tried to become pregnant for more than 1 year without becoming pregnant?	1	2	SITRYPR
	If YES,			
	a. Did you visit a doctor or clinic because you did not become pregnant?	1	2	SIMDPRG
	If YES,			
	i. Was a reason found for why you did not become pregnant?	1	2	SIWHYPR

If YES,
a) Major reason (check only one):

Problem with your hormones or ovulation (producing eggs)	1	
Problem with your tubes or uterus	2	
Endometriosis	3	SIWHYSP
Other problem with you	4	
Partner's problem	5	
Don't know	6	

7. Did you ever have an operation to have one or both of your ovaries taken out?

No	1	
Yes, one taken out	2	
Yes, both taken out	3	SIOVAR
Yes, part of an ovary taken out	4	
Don't know	5	

If YES,
a. How old were you at your last operation? [ ][ ] years SIOVARA

8. Did you ever have an operation to remove your uterus (womb) (hysterectomy)? YES [1] NO [2] SIHYST

If YES,
a. How old were you? [ ][ ] years SIHYSTA

9. Did you ever have an operation to have your tubes tied to prevent pregnancy? YES [1] NO [2] SITUBAL

10. Has a heath care provider ever told you that you had polycystic ovary syndrome or Stein-Leventhal syndrome? YES [1] NO [2] SIPCOS

If YES,
a. How old were you when you were told? [ ][ ] years SIPCOSA

11. Did you ever take any type of estrogen, such as Premarin for 1) relief of menopausal symptoms such as hot flashes or night sweats, or 2) after a hysterectomy with removal of ovaries, or 3) for prevention of disease such as bone loss? (This could include pills, vaginal creams or suppositories, injections, or skin patches.) YES [1] NO [2] SIESTR

If YES,
a. About how many years did you take this? [ ][ ] years SIESTRT

b. Are you still taking estrogen replacement therapy? YES [1] NO [2] SIESTRN

12. Did you ever take oral contraceptives (birth control pills)? YES [1] NO [2] SIBCP

If YES,
a. Altogether, about how long did you take oral contaceptives? [ ][ ] years SIBCPT

b. Are you still taking oral contraceptives? YES [1] NO [2] SIBCPN

Part III / PHYSICAL

O. Anthropometrics

- For O.1 - Weight, record Measure 3 only if first 2 measurements are not within 0.2 kilograms.
- For O.2 - Waist Circumference, and O.3 - Hip Girth, record measure 1 for each before completing Measure 2 and only record Measure 3 if first 2 measurements are not within 0.5 cm.

	Measure 1	Measure 2	Measure 3	
1. Weight	SIWGHT1	SIWGHT2	SIWGHT3	kg
2. Waist Circumference	SIWSTC1	SIWSTC2	SIWSTC3	cm
3. Hip Girth	SIHIP1	SIHIP2	SIHIP3	cm

4. Skin-fold Thickness

Do all skinfold measurements in each trial before going on to the next trial.

		Trial 1	Trial 2	Trial 3	
a. Subscapular	SISFSB	1	2	3	mm
b. Triceps	SISFTR	1	2	3	mm
c. Supra iliac	SISFSI	1	2	3	mm
d. Abdominal	SISFAB	1	2	3	mm
e. Medial calf	SISFMC	1	2	3	mm

5. Sagittal Diameter

Record Measure 3 only if first 2 measurements are not within 1 cm.

	Measure 1	Measure 2	Measure 3	
SISAGD	1	2	3	cm

P. Blood Pressure

1. Supine Ankle/Arm Systolic Blood Pressure

Right arm to be used unless left arm is ≥ 10 mmHg higher, in which case wait 30 seconds, repeat left arm pressure, and enter the repeat result as the first arm pressure

a. Arm	SISSBP	[ ][ ][ ]	mmHg	[1] Right arm [2] Left arm SISSBPA
b. Right dorsalis pedis	SIADORR	[ ][ ][ ]	mmHg	
c. Right tibialis posterior	SIAPOSR	[ ][ ][ ]	mmHg	
d. Left dorsalis pedis	SIADORL	[ ][ ][ ]	mmHg	
e. Left tibialis posterior	SIADOSL	[ ][ ][ ]	mmHg	
f. Arm (same arm as 1.a)	SISSBPF	[ ][ ][ ]	mmHg	

Part IV / COMPLETION

Q. Eligibility/Interest

	YES	NO	
1. Is participant willing to continue with the screening process?	[1]	[2]	SIWILL

If YES, continue.
If NO, STOP. Fill in Eligibility Checklist item E.1.

R. Placebo Medication Dispensed

1. Dispensing of Medication

Run-in 1

METFORMIN LABEL

Remove label from medication before dispensing and affix here. If not dispensed, check here [1]

SINOMT1

Run-in 2

METFORMIN LABEL

Remove label from medication before dispensing and affix here. If not dispensed, check here [1]

SINOMT2