Diabetes Prevention Trial - Type 1
MEDICAL HISTORY

Complete this form every six months, beginning with six month follow-up visit.

Subject ID #: ☐☐☐☐☐☐☐ Subject Initials: ☐☐☐ (F M L) Date: ☐☐ / ☐☐ / ☐☐ (M M / D D / Y Y)

Name of person completing form (please print): ____________________

Date of Visit: ☐☐ / ☐☐ / ☐☐ (M M / D D / Y Y)

Since last visit has subject had:	1=No 2=Yes 3=Unknown	If YES, Specify	Date onset MM/DD/YY	1=Resolved 2=Active
Endocrine Disease				
Thyroid Disease	☐	________	☐☐/☐☐/☐☐	☐
Adrenal Disease	☐	________	☐☐/☐☐/☐☐	☐
Other Endocrine Disease	☐	________	☐☐/☐☐/☐☐	☐
HEENT Disease	☐	________	☐☐/☐☐/☐☐	☐
Pulmonary Disease	☐	________	☐☐/☐☐/☐☐	☐
Asthma	☐	________	☐☐/☐☐/☐☐	☐
Cardiac Disease	☐	________	☐☐/☐☐/☐☐	☐
Gastrointestinal Disease	☐	________	☐☐/☐☐/☐☐	☐
Pernicious Anemia	☐	________	☐☐/☐☐/☐☐	☐
Rheumatologic Disease	☐	________	☐☐/☐☐/☐☐	☐
Lupus Erythematosus	☐	________	☐☐/☐☐/☐☐	☐
Rheumatoid Arthritis	☐	________	☐☐/☐☐/☐☐	☐
Vasculitis	☐	________	☐☐/☐☐/☐☐	☐
Neurologic Disease	☐	________	☐☐/☐☐/☐☐	☐
Grandmal Seizure	☐	Number: ☐☐		
Other Seizures	☐	Type: ________		
Genitourinary Disease	☐	________	☐☐/☐☐/☐☐	☐
Skin Disease	☐	________	☐☐/☐☐/☐☐	☐
Psoriasis	☐	________	☐☐/☐☐/☐☐	☐
Vitiligo	☐	________	☐☐/☐☐/☐☐	☐
Alopecia	☐	________	☐☐/☐☐/☐☐	☐

DMU Use Only
Date rcvd:

Since last visit has subject had:	1=No 2=Yes 3=Unknown	If YES, Specify	Date onset MM/DD/YY	1=Resolved 2=Active
Psychiatric Disease	☐	____________	☐☐/☐☐/☐☐	☐
Neoplastic Disease	☐	____________	☐☐/☐☐/☐☐	☐
Hematologic Disease	☐	____________	☐☐/☐☐/☐☐	☐
Surgical Procedures	☐	____________	☐☐/☐☐/☐☐	
		____________	☐☐/☐☐/☐☐	
		____________	☐☐/☐☐/☐☐	
Reproductive System				
Currently Pregnant	☐	If yes, submit Pregnancy Form (PY)		
Menses Regular	☐	____________	☐☐/☐☐/☐☐	☐
Any Known Allergies	☐	____________	☐☐/☐☐/☐☐	☐
Currently Use Tobacco Products	☐	Frequency: ☐☐ packs per day for ☐☐ years		
Currently Use Alcohol	☐	Frequency: ☐☐ ounces per day for ☐☐ years		

Current Medications

Sulfonylureas	☐
Steroids	☐
Potassium Depleting Diuretics	☐
Beta Blockers	☐
Immunosuppressives	☐
Dilantin	☐
Non DPT-1 Study Therapy for Diabetes Prevention	☐

Other Current Medications (including vitamins, OTCs): ________________

____

____

____

Hypoglycemia Screens

a. Specifically review the signs and symptoms of hypoglycemia with all subjects. Did any episodes of presumed or definite hypoglycemia **which have not yet been reported** occur since the last DPT-1 visit? ☐ 1=No 2=Yes 3=Don't know

If yes, how many times did this occur since the last DPT-1 visit? ☐☐

List dates of occurrence:

M M / D D / Y Y	M M / D D / Y Y	M M / D D / Y Y
☐☐ / ☐☐ / ☐☐	☐☐ / ☐☐ / ☐☐	☐☐ / ☐☐ / ☐☐
☐☐ / ☐☐ / ☐☐	☐☐ / ☐☐ / ☐☐	☐☐ / ☐☐ / ☐☐

b. Since your last visit to the clinic, have you had any episodes of the following that you have not reported to us? (If yes, submit Adverse Event Form (AE) for each event.)

1=No
2=Yes

- ☐ Seizures
- ☐ Loss of consciousness or fainting
- ☐ Coma
- ☐ Hospitalization for any reason? Specify, ____________________
- ☐ Serious disease diagnosed? Specify, ____________________

Pregnancy -

Since your last clinic visit, have you been pregnant? ☐ 1=No 2=Yes (If yes, submit Pregnancy Form.)
(If pregnant take appropriate action to stop DPT-1 treatment and complete Pregnancy Form.)