

Adverse Event Reporting Form

Initial Report

* These fields are required in order to SAVE the form (if not indicating post-partum depression counseling or genetic counseling)

Adverse event occurrence date	aecurdtage	2184	2185	2186	(DD MMM YYYY) *
Adverse event report date	aereportage	2167	2168	2169	(DD MMM YYYY) *
Event Category	aecategory	2182			* Help
Event Supra-term "Type of Event"	aesupraordinateterm	2173			*
Event Select "Site or Modifier"		2190			
Severity	severity	2178			*
Event Details "Description"	aedetails	2191			
Expected	aexpected	2179			<input type="radio"/> Yes <input type="radio"/> No *
Location of event treatment		2175			Other
		2176			
Causality (by reporter)	aecausalitybyreporter	2180			*
Was this a serious event?	aeserious	2188			<input type="radio"/> Yes <input type="radio"/> No *
Was the adverse event associated with any of the following? (check all that apply)	aassociations_developmentofacon aassociations_developmentofaper 2189 aassociations_death aassociations_hospitalizationor aassociations_lifethreatening	<input type="checkbox"/> Development of a congenital anomaly or birth defect <input type="checkbox"/> Development of a permanent, serious, disabling or incapacitating condition <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization or prolonged hospitalization <input type="checkbox"/> Life threatening			
Patient status (at time of report):		2181			*
Adverse event resolved date		2170	2171	2172	(DD MMM YYYY)
Date of death	aedeathage	2192	2193	2194	(DD MMM YYYY)
Was this subject referred for genetic counseling?	refergeneticcounseling	2261			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was this subject referred for post-partum depression counseling?	referpostpartumdepressioncouns	2262			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Additional comments	comments	2177			
Staff Code		2259			

Save Form

Submit for Review

Print

Close Window

English Teleform

German Teleform

Swedish Teleform

Finnish Teleform

Spanish Teleform

TEDDY**The Environmental Determinants of Diabetes in the Young****TEDDY Annual Questionnaire**

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Date Form was Reviewed	2032 2033 2034 *	Visit Location Code	*
------------------------	------------------	---------------------	---

TEDDY Staff Code	*
------------------	---

2035

Visit	<input checked="" type="radio"/> 15 Months Visit	<input type="radio"/> 27 Months	<input type="radio"/> 39 Months	<input type="radio"/> 48 Months
	<input type="radio"/> 5 Year	<input type="radio"/> 6 Year	<input type="radio"/> 7 Year	<input type="radio"/> 8 Year
	<input type="radio"/> 9 Year	<input type="radio"/> 10 Year	<input type="radio"/> 11 Year	<input type="radio"/> 12 Year
	<input type="radio"/> 13 Year	<input type="radio"/> 14 Year	<input type="radio"/> 15 Year	

Valid date range for this visit : **27 Sep 2005** until **11 Aug 2006**.

1. Date you completed this questionnaire:		*	event_age
--	--	---	------------------

We are interested in your reactions to your baby's genetic test result and your experience in the TEDDY study. Thank you for taking the time to answer the questions below. Please remember that there are no right or wrong answers and all answers are confidential.

1986

2. What is your relationship to the TEDDY child?*	<input checked="" type="radio"/> Mother	<input type="radio"/> Father	<input type="radio"/> Other Primary Caretaker	<input type="radio"/> Other
--	---	------------------------------	---	-----------------------------

If other, specify:	1987	Code:	1988	RelationToChildCode
---------------------------	------	--------------	------	----------------------------

1989

3. Compared to other children, do you think your child's risk for developing diabetes is: (Mark one answer)	<input checked="" type="radio"/> Much Lower	<input type="radio"/> Somewhat lower	<input type="radio"/> About the same	<input type="radio"/> Somewhat higher	<input type="radio"/> Much higher
--	---	--------------------------------------	--------------------------------------	---------------------------------------	-----------------------------------

1990

4. When you think about your child's future, do you think: (Mark one answer)	<input checked="" type="radio"/> The child will develop diabetes in the near future	<input type="radio"/> The child will eventually develop diabetes but a long time from now	<input type="radio"/> The child will never develop diabetes	<input type="radio"/> You're unsure what will happen
---	---	---	---	--

1991

5. How often do you worry that your child will get diabetes? (Mark one answer)	<input checked="" type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often	<input type="radio"/> Very often
---	--	------------------------------	---------------------------------	-----------------------------	----------------------------------

1992

6. When you think about your child's risk for developing diabetes, you feel: (Mark one answer on each line)	<input checked="" type="radio"/> Not at all calm	<input type="radio"/> Somewhat calm	<input type="radio"/> Moderately calm	<input type="radio"/> Very calm	ChildRiskDiabetesCalm
--	--	-------------------------------------	---------------------------------------	---------------------------------	------------------------------

1993

	<input checked="" type="radio"/> Not at all worried	<input type="radio"/> Somewhat worried	<input type="radio"/> Moderately worried	<input type="radio"/> Very worried	ChildRiskDiabetesWorried
--	---	--	--	------------------------------------	---------------------------------

1994

	<input checked="" type="radio"/> Not at all relaxed	<input type="radio"/> Somewhat relaxed	<input type="radio"/> Moderately relaxed	<input type="radio"/> Very relaxed	ChildRiskDiabetesRelaxed
--	---	--	--	------------------------------------	---------------------------------

1995

	<input checked="" type="radio"/> Not at all tense	<input type="radio"/> Somewhat tense	<input type="radio"/> Moderately tense	<input type="radio"/> Very tense	ChildRiskDiabetesTense
--	---	--------------------------------------	--	----------------------------------	-------------------------------

1996

	<input checked="" type="radio"/> Not at all at-ease	<input type="radio"/> Somewhat at-ease	<input type="radio"/> Moderately at-ease	<input type="radio"/> Very at-ease	ChildRiskDiabetesEase
--	---	--	--	------------------------------------	------------------------------

1997

	<input checked="" type="radio"/> Not at all nervous	<input type="radio"/> Somewhat nervous	<input type="radio"/> Moderately nervous	<input type="radio"/> Very nervous	ChildRiskDiabetesNervous
--	---	--	--	------------------------------------	---------------------------------

7. How often do you feel that each phrase applies to you in the past few weeks? answer on each line a-f) (Mark one

1998 **a. I feel that I am useful and needed:** FeelUsefulNeeded
 All of the time Some of the time Occassionally Not at all

1999 **b. I have crying spells or feel like it::** HaveCryingSpells
 All of the time Some of the time Occassionally Not at all

2000 **c. I find I can think quite clearly:** CanThinkClearly
 All of the time Some of the time Occassionally Not at all

2001 **d. My life is pretty full:** LifePrettyFull
 All of the time Some of the time Occassionally Not at all

2002 **e. I feel downhearted and blue:** FeelDownHeartedBlue
 All of the time Some of the time Occassionally Not at all

2003 **f. I enjoy things I do:** EnjoyThings
 All of the time Some of the time Occassionally Not at all

8. Please read each statement below and mark whether you agree or disagree with the statement. (Mark one answer on each line a-c)

2004 **a. I can do something to reduce my child's risk of developing diabetes.** CanDoSomethingReduceRisk
 Strongly agree Agree Neutral Disagree Strongly disagree

2005 **b. Medical professionals can do something to reduce my child's risk for developing diabetes.** ProffCanDoSomethingReduceRisk
 Strongly agree Agree Neutral Disagree Strongly disagree

2006 **c. It is up to chance or fate whether my child develops diabetes.** UpToChanceFate
 Strongly agree Agree Neutral Disagree Strongly disagree

2007 **9. Sometimes people do things to try to stop their child from getting diabetes. Sometimes people do nothing special to try to prevent diabetes in the child. In the last year have you done anything to try to stop or prevent your child from getting diabetes?*** DoneAnythingStopDiabetes
 No Yes
 If you answered **Yes**, what kind of things have you done to try and stop or prevent diabetes in your child?

Code	<input type="text" value="2013"/>	DoneThisStopsDiabetesCode1
Code	<input type="text" value="2014"/>	DoneThisStopsDiabetesCode2
Code	<input type="text" value="2015"/>	DoneThisStopsDiabetesCode3
Code	<input type="text" value="2016"/>	DoneThisStopsDiabetesCode4
Code	<input type="text" value="2017"/>	DoneThisStopsDiabetesCode5

Codes	
<input type="text" value="3101"/>	
<input type="text"/>	
<input type="text"/>	

2018

10. In the past year have you done anything to monitor or keep an eye on your child's risk of developing diabetes?* DoneAnythingMonitorDiabetes

No Yes

If you answered **Yes**, what kinds of things have you done to monitor or keep an eye on your child's risk of developing diabetes?

Code	<input type="text" value="2024"/>	DoneThisMonitorDiabetesCode1
Code	<input type="text" value="2025"/>	DoneThisMonitorDiabetesCode2
Code	<input type="text" value="2026"/>	DoneThisMonitorDiabetesCode3
Code	<input type="text" value="2027"/>	DoneThisMonitorDiabetesCode4
Code	<input type="text" value="2028"/>	DoneThisMonitorDiabetesCode5

2029

11. Overall, how do you feel about having your child participate in the TEDDY study? FeelChildParticipation

Like it a lot
 Like it a little
 It is OK
 Dislike it a little
 Dislike it a lot

2030

12. Do you think your child's participation in the TEDDY study was a good decision? ChildParticipationGoodDecision

A great decision
 A good decision
 An ok decision
 A bad decision
 A very bad decision

2031

13. Would you recommend the TEDDY study to a friend? RecommendTEDDYStudy

No
 Yes
 Maybe

Local use only

Subject ID

TEDDY Study



Annual Child Questionnaire

*By now you may have read the **TEDDY Junior Scientists** books. Just like you, **Will and Emma** are helping the **TEDDY** scientists understand why some kids get diabetes and others do not. The last book was called **Will and Emma Meet the TEDDY Scientists**. In the story, **Will and Emma** went to the **TEDDY** lab where they went on an exciting trip inside the body and learned a lot about genes, cells, and diabetes. We want to know what you think about that book.*

1. Date you completed this questionnaire ___/___/___ event_age

2. Did you read the book, **Will and Emma Meet the TEDDY Scientists?**

<input type="radio"/> No, I got the book, but I didn't read it.	<input type="radio"/> No, I didn't get the book.	<input type="radio"/> Yes, I did read the book.
---	--	---

3. How was the book, **Will and Emma Meet the TEDDY Scientists?** (Pick one answer.)

<input type="radio"/> I liked it a lot.	<input type="radio"/> It was OK.	<input type="radio"/> I did not like it at all.
---	----------------------------------	---

4. Did the book **Will and Emma Meet the TEDDY Scientists** help you understand what **TEDDY** is about? (Pick one answer).

<input type="radio"/> It helped me a lot to understand what TEDDY is about.
<input type="radio"/> It helped me a little to understand what TEDDY is about.
<input type="radio"/> It did not help me understand what TEDDY is about.

Local use only

Subject ID

5. How do you feel about being in the TEDDY study? (Pick one answer). _9HOWDOYOUFEELABOUTBEINGINTHE

<input type="radio"/> I like it a lot.	<input type="radio"/> It is OK.	<input type="radio"/> I do not like it at all.
--	---------------------------------	--

_10HOWDOYOUFEELABOUTYOURPARENT

6. How do you feel that your parents decided you should be in TEDDY? (Pick one answer).

<input type="radio"/> I am happy to be in TEDDY.	<input type="radio"/> I am OK with being in TEDDY.	<input type="radio"/> I am not happy about being in TEDDY.
--	--	--

7. If you had a friend who was asked to be in a study like TEDDY would you tell them they should do it? _1IFYOUHADAFRIENDWHOWASASKEDT

<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Maybe
--------------------------	---------------------------	-----------------------------

8. Risk is the chance that something may or may not happen. What do you think about your risk of getting diabetes? (Pick one answer).

I think I have . . .

_4WHATDOYOUTHINKABOUTYOURRISKO

a **smaller** risk of getting diabetes than my friends who are not in TEDDY.

the **same** risk of getting diabetes as my friends who are not in TEDDY.

a **higher** risk of getting diabetes than my friends who are not in TEDDY.

I am not sure about my risk of getting diabetes.

Some families do things they think might stop kids from getting diabetes. Some families do not do these things.

_7DOYOUDOTHINGSYOUTHINKMIGHTST

9. Do you do things you think might stop you from getting diabetes?

No

Yes *If Yes, what do you do?* **_7CHILDSTOPDIABETESYESCOMMENT** _____

Code (office use only): _____

_8DOYOURPARENTSDOTHINGSTHEYTHI

10. Do your parents do things they think might stop you from getting diabetes?

No

Yes *If Yes, what do they do?* **_8PARENTSTOPDIABETESYESCOMMENT** _____

Code (office use only): _____

I don't know

11. Do you worry about getting diabetes? (Pick one answer.) **_5DOYOUWORRYABOUTGETTINGDIABET**

I never worry.

I worry sometimes.

I worry a lot.

Please answer the next questions about how you feel. There are no right or wrong answers. If you do not understand a question, you may skip that question and go on to the next one. Fill in one circle answer on each row.

12. When you think about your risk of getting diabetes, how do you feel? (Pick one answer on each line a – t)

a. I feel	<input type="radio"/> Very calm	<input type="radio"/> Calm _6AIFEELCALM	<input type="radio"/> Not calm
b. I feel	<input type="radio"/> Very upset	<input type="radio"/> Upset _6BIFEELUPSET	<input type="radio"/> Not upset
c. I feel	<input type="radio"/> Very pleasant	<input type="radio"/> Pleasant _6CIFEELPLEASANT	<input type="radio"/> Not pleasant
d. I feel	<input type="radio"/> Very nervous	<input type="radio"/> Nervous _6DIFEELNERVOUS	<input type="radio"/> Not nervous
e. I feel	<input type="radio"/> Very jittery	<input type="radio"/> Jittery _6EIFEELJITTERY	<input type="radio"/> Not jittery
f. I feel	<input type="radio"/> Very rested	<input type="radio"/> Rested _6FIFEELRESTED	<input type="radio"/> Not rested
g. I feel	<input type="radio"/> Very scared	<input type="radio"/> Scared _6GIFEELSCARED	<input type="radio"/> Not scared
h. I feel	<input type="radio"/> Very relaxed	<input type="radio"/> Relaxed _6HIFEELRELAXED	<input type="radio"/> Not relaxed
i. I feel	<input type="radio"/> Very worried	<input type="radio"/> Worried _6IIFEELWORRIED	<input type="radio"/> Not worried
j. I feel	<input type="radio"/> Very satisfied	<input type="radio"/> Satisfied _6JIFEELSATISFIED	<input type="radio"/> Not satisfied
k. I feel	<input type="radio"/> Very frightened	<input type="radio"/> Frightened _6KIFEELFRIGHTENED	<input type="radio"/> Not frightened
l. I feel	<input type="radio"/> Very happy	<input type="radio"/> Happy _6LIFEELHAPPY	<input type="radio"/> Not happy

Local use only

Subject ID

m. I feel	<input type="radio"/> Very sure	<input type="radio"/> Sure _6MIFEELSURE	<input type="radio"/> Not sure
n. I feel	<input type="radio"/> Very good	<input type="radio"/> Good _6NIFEELGOOD	<input type="radio"/> Not good
o. I feel	<input type="radio"/> Very troubled	<input type="radio"/> Troubled _6OIFEELTROUBLED	<input type="radio"/> Not troubled
p. I feel	<input type="radio"/> Very bothered	<input type="radio"/> Bothered _6PIFEELBOTHERED	<input type="radio"/> Not bothered
q. I feel	<input type="radio"/> Very nice	<input type="radio"/> Nice _6QIFEELNICE	<input type="radio"/> Not nice
r. I feel	<input type="radio"/> Very terrified	<input type="radio"/> Terrified _6RIFEELTERRIFIED	<input type="radio"/> Not terrified
s. I feel	<input type="radio"/> Very mixed-up	<input type="radio"/> Mixed-up _6SIFEELMIXEDUP	<input type="radio"/> Not mixed-up
t. I feel	<input type="radio"/> Very cheerful	<input type="radio"/> Cheerful _6TIFEELCHEERFUL	<input type="radio"/> Not cheerful

Thank you very much for your time.

Local use only

Subject ID

Office Use Only

Local Code: _____

Clinical Center: _____

Subject ID: _____

Visit Location Code: _____

Date Questionnaire was Reviewed: ___ / ___ / _____

(DD/MMM/YYYY)

Visit: ___ 10 year 11 year 12 year 13 year 14 year 15 year

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form: _____



Local Use Only

SubjectID

TEDDY Study



Annual Child Questionnaire

© 1970 Charles D. Spielberger All rights reserved in all media. Published by Mind Garden, Inc.,
www.mindgarden.com This instrument was modified - by: Suzanne Bennett Johnson, Ph.D., Florida State
College of Medicine -- from the original.

Date you answered these questions: _____

(if you need help with the date, please ask your parent)

1. Risk is the chance that something may or may not happen. What do you think about your risk of getting diabetes? (Pick one answer)

4WHATDOYOUTHINKABOUTYOURRISKO

I think I have . . .

<input type="radio"/> a smaller risk of getting diabetes than my friends who are not in TEDDY.
<input type="radio"/> the same risk of getting diabetes as my friends who are not in TEDDY.
<input type="radio"/> a higher risk of getting diabetes than my friends who are not in TEDDY.
<input type="radio"/> I am not sure about my risk of getting diabetes.

2. Do you worry about getting diabetes? (Pick one answer) 5DOYOUWORRYABOUTGETTINGDIABET

<input type="radio"/> I never worry.	<input type="radio"/> I worry sometimes.	<input type="radio"/> I worry a lot.
--------------------------------------	--	--------------------------------------

3. Please answer the next questions about how you feel. There are no right or wrong answers. If you do not understand a question, you may skip that question and go on to the next one.

When you think about your risk of getting diabetes, how do you feel? (Pick one answer on each line a – f)

a. I feel	<input type="radio"/> Very worried	<u>6</u> IFEELWORRIED <input type="radio"/> Worried	<input type="radio"/> Not worried
b. I feel	<input type="radio"/> Very frightened	<u>6</u> KIFEELFRIGHTENED <input type="radio"/> Frightened	<input type="radio"/> Not frightened
c. I feel	<input type="radio"/> Very happy	<u>6</u> LIFEELHAPPY <input type="radio"/> Happy	<input type="radio"/> Not happy
d. I feel	<input type="radio"/> Very good	<u>6</u> NIFEELGOOD <input type="radio"/> Good	<input type="radio"/> Not good
e. I feel	<input type="radio"/> Very troubled	<u>6</u> OIFEELTROUBLED <input type="radio"/> Troubled	<input type="radio"/> Not troubled
f. I feel	<input type="radio"/> Very nice	<u>6</u> OIFEELNICE <input type="radio"/> Nice	<input type="radio"/> Not nice

Some families do things they think might stop kids from getting diabetes. Some families do not do these things.

4. Do you do things you think might stop you from getting diabetes? **_7DOYOUOTHINGSYOUTHINKMIGHTST**

<input type="radio"/> No	
<input type="radio"/> Yes	<i>If Yes, what do you do?</i> _7CHILDSTOPDIABETESYESCOMMENT

	Code (office use only) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

5. Do your parents do things they think might stop you from getting diabetes? **_8DOYOURPARENTSDOTHINGSTHEYTHI**

<input type="radio"/> No	
<input type="radio"/> Yes	<i>If Yes, what do they do?</i> _8PARENTSTOPDIABETESYESCOMMENT

	Code (office use only) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="radio"/> I don't know	

6. How do you feel about being in the TEDDY study? (Pick one answer) **_9HOWDOYOUFEELABOUTBEINGINTHET**

I like it a lot.

It is OK.

I do not like it at all.

7. How do you feel about your parents' decision that you should be in TEDDY? (Pick one answer) **_10HOWDOYOUFEELABOUTYOURPARENT**

It was a good decision.

It was an okay decision.

It was a bad decision.

8. If you had a friend who was asked to be in a study like TEDDY would you tell them they should do it? (Pick one answer) **_11IFYOUHADAFRIENDWHOWASASKEDT**

No

Yes

Maybe

Thank you very much for your time.

English Teleform

German Teleform

Swedish Teleform

Finnish Teleform

Spanish Teleform

TEDDY

The Environmental Determinants of Diabetes in the Young

Child Behavior Checklist

* These fields are required in order to SAVE the form.
 * These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Date Questionnaire Reviewed	3429 3430 3431 *	Visit Location Code	*
-----------------------------	------------------	---------------------	---

TEDDY Staff Code	* /	
------------------	-----	--

3455

Form completed **Form Completed**

At home
 In clinic before blood draw
 In clinic after blood draw
 By phone

3432

Visit **VISIT**

42 months (form was completed when child was between 36 months and 48 months of age)
 54 months (form was completed when child was between 48 months plus one day and 60 months of age)
 66 months (form was completed when child was between 60 months plus one day and 72 months of age)

Date you completed this questionnaire: * **Event_age**

RELATIONSHIP TO EDDY CHILD CODE
Your relationship to the child:
3302

Mother
 Father
 Mother + Father completed form together
 Other Primary Caretaker
 Other **OTHERS SPECIFY**

Code 3426

3303	1. Aches or pains (without medical cause; do not include stomach or headaches) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	24. Doesn't eat well DOESNTEATWELL	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3326
3304	2. Acts too young for age ACTSTOOPYOUNGFORAGE	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	25. Doesn't get along with other children <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3327
3305	3. Afraid to try new things AFRAIDTOTRYNEWTINGS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	26. Doesn't know how to have fun; acts like a little adult DOESNTKNOWHOWTOHAVEFUNLITTLEAD	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3328
3306	4. Avoids looking others in the eye <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	27. Doesn't seem to feel guilty after misbehaving <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3329
3307	5. Can't concentrate, can't pay attention for long <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	28. Doesn't want to go out of home <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3330
3308	6. Can't sit still, restless, or hyperactive <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	29. Easily frustrated EASILYFRUSTRATED	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3331
3309	7. Can't stand having things out of place <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	30. Easily jealous EASILYJEALOUS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3332
3310	8. Can't stand waiting, wants everything now <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	31. Eats or drinks things that are not food - don't include sweets. EATSDRINKSTHINGSTHATARENOTFOOD	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3333
3311	9. Chews on things that aren't edible <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	32. Fears certain animals, situations, or places. <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3334
3312	10. Clings to adults or too dependent <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	33. Feelings are easily hurt FEELINGSEASILYHURT	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3335
3313	11. Constantly seeks help CONSTANTLYSEEKSHELP	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	34. Gets hurt a lot, accident prone <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3336
3314	12. Constipated, doesn't move bowels (when not sick) CONSTIPATEDDOESNTMOVEBOWELSWHE	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	35. Gets in many fights GETSINMANYFIGHTS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3337
3315	13. Cries a lot CRIESALOT	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	36. Gets into everything GETSINTOEVERYTHING	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3338
3316	14. Cruel to animals CRUELTOANIMALS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	37. Gets too upset when separated from parents <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3339
3317	15. Defiant DEFIANT	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	38. Has trouble getting to sleep HASTROUBLEGETTINGTOSLEEP	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3340
3318	16. Demands must be met immediately <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	39. Headaches (without medical cause) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3341
3319	17. Destroys his/her own things DESTROYSONWNTINGS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	40. Hits others HITSOTHERS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3342
3320	18. Destroys things belonging to his/her family or other children DESTROYSTHINGSBELONGINGTOFAMIL	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	41. Holds his/her breath HOLDSHISHERBREATH	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3343
3321	19. Diarrhea or loose bowels (when not sick) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	42. Hurts animals or people without meaning to <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3344
3322	20. Disobedient DISOBEDIENT	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	43. Looks unhappy without good reason <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3345
3323	21. Disturbed by any change in routine <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	44. Angry moods ANGRYMOODS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3346
3324	22. Doesn't want to sleep alone <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	45. Nausea, feels sick (without medical cause) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3347
3325	23. Doesn't answer when people talk to him/her <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	46. Nervous movements or twitching <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3348

- 3303.1 ACHESORPAINS
- 3306.4 AVOIDSLOOKINGOTHERSINTHEEYE
- 3307.5 CANTPAYATTENTIONFORLONG
- 3308.6 CANTSITSTILLHYPERACTIVE
- 3309.7 CANTSTANDTHINGSOUTOFPLACE
- 3310.8 CANTSTANDWAITINGIMPATIENT
- 3311.9 CHEWSONINEDIBLETHINGS
- 3312.10 CLINGSTOADULTSTOODEPENDENT
- 3318.16 DEMANDSMUSTBEMETIMMEDIATELY
- 3321.19 DIARRHEALOOSEBOWELSWHENNOTSICK
- 3323.21 DISTURBEDBYANYCHANGEINROUTINE
- 3324.22 DOESNTWANTTOSLEEPALONE
- 3325.23 DOESNTALKWHENPEOLETALKTOCHIL
- 3327.25 DOESNTGETALONGWITHOTHERCHILDR
- 3329.27 DOESNTSEEMGUILTYAFTERMISBEHAVI
- 3330.28 DOESNTWANTTOGOOUTOFHOME
- 3334.32 FEARS CERTAIN ANIMALS SITUATIONS
- 3336.34 GETSHURTA LOT ACCIDENT PRONE
- 3339.37 GETSTOOPSETWHENSEPARATEDFROMP
- 3341.39 HEADACHESWITHOUTMEDICALCAUSE
- 3344.42 HURTSANIMALSORPEOPLEWITHOUTMEA
- 3345.43 LOOKSUNHAPPYWITHOUTGOODREASON
- 3347.45 NAUSEAFEELSSICKWITHOUTMEDICALC
- 3348.46 NERVOUSMOVEMENTSORTWITCHING

3349	47. Nervous, highstrung, or tense <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	74. Sleeps less than most kids during day and/or night <i>SLEEPSLESSTHANMOSTKIDSNIGHT</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3376
3350	48. Nightmares <i>NIGHTMARES</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	75. Smears or plays with bowel movements <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3377
3351	49. Overeating <i>OVEREATING</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	76. Speech problem <i>SPEECHPROBLEM</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3378
3352	50. Overtired <i>OVERTIRED</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	77. Stares into space or seems preoccupied <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3379
3353	51. Shows panic for no good reason <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	78. Stomachaches or cramps (without medical cause) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3380
3354	52. Painful bowel movements (without medical cause) <i>PAINFULBOWELMOVEMENTSWITHOUTME</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	79. Rapid shift between sadness and excitement <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3381
3355	53. Physically attacks people <i>PHYSICALLYATTACKSPEOPLE</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	80. Strange behavior <i>STRANGEBEHAVIOR</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3382
3356	54. Picks nose, skin, or other parts of body <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	81. Stubborn, sullen, or irritable <i>STUBBORN SULLEN OR IRRITABLE</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3383
3357	55. Plays with own sex parts too much <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	82. Sudden change in mood or feelings <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3384
3358	56. Poorly coordinated or clumsy <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	83. Sulks a lot <i>SULKSALOT</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3385
3359	57. Problems with eyes (without medical condition) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	84. Talks or cries out in sleep <i>TALKSORCRIESOUTINSLEEP</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3386
3360	58. Punishment doesn't change his/her behavior <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	85. Temper tantrums or hot temper <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3387
3361	59. Quickly shifts from one activity to another <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	86. Too concerned with neatness or cleanliness <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3388
3362	60. Rashes or other skin problems (without medical cause) <i>RASHESOROTHERSKINPROBLEMSWITHO</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	87. Too fearful or anxious <i>TOOFEARFULORANXIOUS</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3389
3363	61. Refuses to eat <i>REFUSESTOEAT</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	88. Uncooperative <i>UNCOOPERATIVE</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3890
3364	62. Refuses to play active games <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	89. Underactive, slow moving, or lacks energy <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3391
3365	63. Repeatedly rocks head or body <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	90. Unhappy, sad or depressed <i>UNHAPPYSADORDEPRESSED</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3392
3366	64. Resists going to bed at night <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	91. Unusually loud <i>UNUSUALLYLOUD</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3393
3367	65. Resists toilet training <i>RESISTSTOILETRAINING</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	92. Upset by new people or situations <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3394
3368	66. Screams a lot <i>SCREAMSALOT</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	93. Vomiting, throwing up (without medical cause) <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3395
3369	67. Seems unresponsive to affection <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	94. Wakes up often at night <i>WAKESUPTOFTENATNIGHT</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3396
3370	68. Self-conscious or easily embarrassed <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	95. Wanders away <i>WANDERSAWAY</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3397
3371	69. Selfish or won't share <i>SELFISHORWONTSHARE</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	96. Wants a lot of attention <i>WANTSALOTOFFATTENTION</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3398
3372	70. Shows little affection toward people <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	97. Whining <i>WHINING</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3399
3373	71. Shows little interest in things around him <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	98. Withdrawn, doesn't get involved with others <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3400
3374	72. Shows too little fear of getting hurt <i>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	99. Worries <i>WORRIES</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3401
3375	73. Too shy or timid <i>TOOSHORTIMID</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2			

3349.47 NERVOUSHIGHSTRUNGORTENSE
3353.51 SHOWSPANICFORNOGOODREASON
3356.54 PICKSNOSESKINOROTHERBODYPART
3357.55 PLAYSWITHOWNSEXPARTSTOOMUCH
3358.56 POORLYCOORDINATEDORCLUMSY
3359.57 PROBLEMSWITHEYESWITHOUTMEDCOND
3360.58 PUNISHMENTDOESNTCHANGEBEHAVIOR
3361.59 QUICKLYSHIFTSFROMONEACTIVITYTO
3364.62 REFUSESTOPLAYACTIVEGAMES
3365.63 REPEATEDLYROCKSHEADORBODY
3366.64 RESISTSGOINGTOBEDATNIGHT
3369.67 SEEMSUNRESPONSIVETOAFFECTION
3370.68 SELFCONCIOUSEASILYEMBARRASSED
3372.70 SHOWSLITTLEAFFECTIONTOWARDPEOP
3373.71 SHOWSLITTLEINTERESTINTHINGSARO
3374.72 SHOWSTOOLITTLEFEAROFGETTINGHUR
3377.75 SMEARSORPLAYSWITHBOWELMOVEMENT
3379.77 STARESINTOSPACEORPREOCCUPIED
3380.78 STOMACHACHESORCRAMPSWITHOUTMED
3381.79 RAPIDSHIFTBETWEENSADNESSANDEXC
3384.82 SUDDENCHANGEINMOODORFEELINGS
3387.85 TEMPERTANTRUMSORHOTTEMPER
3388.86 TOOCONCERNEDWITHNEATNESSORCLEA
3391.89 UNDERACTIVESLOWMOVINGORLACKSEN
3394.92 UPSETBYNEWPEOPLEORSITUATIONS
3395.93 VOMITINGTHROWINGUPWITHOUTMEDIC
3400.98 WITHDRAWNDOESNTGETINVOLVEDWITH

Subject ID: _____

Celiac Disease Diagnosis Form

Office Use Only

Local Code:..... Clinical Center:.....

Subject ID:..... Visit Location Code:.....

Date form completed: __/__/____/____ (DD/MMM/YYYY – Example 01/JAN/2004)

Person Completing Form:.....

TEDDY Staff Code of person completing form: _____

Subject ID: _____

Tissue transglutaminase antibodies (tTGAb)

Date of collection of the initial TEDDY tTGAb positive sample (DD/MMM/YYYY):

___/___/___ **INITCOLTTGABPOSITIVEAGE**

AGECHILDINITTTGABPOSITIVEYEARS AGECHILDINITTTGABPOSITIMON

Age of the child: ___ years ___ months

Result (Units) for initial TEDDY tTGAb positive sample:

RESINITIALTTGABPOSITIVE

___ . ___ ___ positive value (for example 0.030)

negative value (for example -0.030)

Laboratory: Bristol Denver

LABINITTTGABPOSITIVE

Date of collection of the confirmatory TEDDY tTGAb positive sample (DD/MMM/YYYY):

___/___/___ **CONFIRMTTGABPOSITIVEAGE**

AGECHILDCONFIRMTTGABPOSITIVEYEAR AGECHILDCONFIRMTTGABPOSITIMON

Age of the child: ___ years ___ months

Result (Units) for confirmatory TEDDY tTGAb positive sample:

RESCONFIRMTTGABPOSITIVE

___ . ___ ___ positive value (for example 0.030)

negative value (for example -0.030)

Laboratory: Bristol Denver

LABCONFIRMTTGABPOSITIVESAMPLE

Date of collection of any additional confirmatory tTGAb positive sample (DD/MMM/YYYY):

___/___/___ **ADDCONFIRMTTGABPOSITIVEAGE**

AGEYEARADDCONFIRMTTGABPOSITIVE AGE MONTHSADDCONFIRMTTGABPOSITIVE

Age of the child: ___ years ___ months

Result (Units) for any additional confirmatory tTGAb positive sample:

RESADDCONFIRMTTGABPOSITIVE

___ . ___ ___ positive value (for example 0.030)

negative value (for example -0.030)

Laboratory: Bristol Denver

LABADDCONFIRMTTGABPOSITIVE

Celiac disease diagnosis

Was celiac disease confirmed by intestinal biopsy? Yes No Don't know

CELIACCONFIRMBYINTESTINALBIOPS

If YES, complete the following:

Date of biopsy (DD/MMM/YYYY): ___/___/___ **CELIACCONFINTESTIBIOPSYAGE**

Age at biopsy: ___ years ___ months

AGEATBIOPSYINYEARS AGEATBIOPSYINMONTH

Subject ID: _ _ _ _ _

Biopsy procedure: Single intestinal biopsy by Watson capsula Yes No Don't know **SININTESTIBIOPSYBYWATCAP**

Serial biopsies by upper endoscopy Yes No Don't know **SERIALBIOPBYUPPENDOS**

Provider/facility where biopsy was done... **WHEREBIOPSYWASDONELINE1**

Do we have signed medical release? Yes No Don't know **HAVESIGNEDMEDICALRELEASE**

Biopsy result after histological classification (or corresponding to Marsh score) (choose one option): **BIOPSYRESULTAFTHISTOCLASSIFI**

- Normal mucosa (Marsh 0)
- Increased intra-epithelial lymphocyte (IEL) count only (i.e. >25 IEL/100 enterocytes) (Marsh 1)
- Increased IELs; crypt hyperplasia; normal villous structure (Marsh 2)
- Mild villous flattening (partial villous atrophy); increased IELs; crypt hyperplasia (Marsh 3a)
- Marked villous flattening (subtotal villous atrophy); increased IELs; crypt hyperplasia (Marsh 3b)
- Flat mucosa (total villous atrophy); increased IELs; crypt hyperplasia (Marsh 3c)
- Flat mucosa (total villous atrophy); increased IELs; normal crypt height (Marsh 4)
- Result unknown, inconclusive, insufficient sample

Have the parents refused biopsy despite positive tTGAb test? Yes No Don't know

If **YES**, complete the following (mark all that apply): **WHYBIOPSYNOTPERFORME_THEPARENTSR**

- The child had no symptoms **WHYBIOPSYNOTPERFORME_THECHILDHAD**
- The child was placed on gluten-free diet without biopsy **WHYBIOPSYNOTPERFORME_THECHILDWAS**
- The biopsy would be too expensive **WHYBIOPSYNOTPERFORME_THEBIOPSYWO**
- Other reason:..... **WHYBIOPSYNOTPERFORME_OTHERREASON**

Code
CODEWHYBIOPSYNOTPERFORM
_ _ _ _ _

Gluten-free diet (GFD)

Did the child receive a GFD before 24 months of age? Yes No Don't know

If **YES**, complete the following:

Subject ID: _____

Duration of GFD: ___ months
Did the child get GFD counselling from a dietician? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Did the child receive a GFD after the initial positive tTGAb test in TEDDY? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Did the child receive a GFD after the second positive tTGAb test in TEDDY? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
If YES , complete the following:
Start of gluten-free diet (DD/MMM/YYYY): <u> </u> / <u> </u> / <u> </u> / <u> </u> GLUTENFREEDIETSTARTEDAGE
Duration of GFD: ___ months STARTGLUTENFREEDIETAGE STOPOFGLUTENFREEDIETAGE
Did the child get dietary counselling from a dietician? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know CHILDCGETDIETCOUNSELDIETI
Is the child currently on a strict GFD (free from wheat, rye, barley and oat) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know ISTHECHILDCURRENTLYSTRICTGFD
Does the child's current diet contain oats? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know CHILDSCURRENTDIETCONTAINOATS
How often does the child consume food containing gluten (<u>choose one option</u>)? CHILDCONSUMEFOODCONTAINGLUTEN
<input type="radio"/> Never
<input type="radio"/> Less than once per month
<input type="radio"/> About once per month
<input type="radio"/> Several times a month
<input type="radio"/> Several times a week
<input type="radio"/> Nearly every day
<input type="radio"/> Don't know
Is diagnosis of celiac disease considered confirmed after follow-up with GFD? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

Has the child had or is currently having any of the following problems? (Mark all that apply)

Problems	Before the second positive tTGAb test in TEDDY	After the second positive tTGAb test in TEDDY and before gluten-free diet was started	After gluten-free diet was started
Chronic constipation CHRONICCONSTIPATION_BEFORETHSECO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent loose stools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal discomfort ABDOMINALDISCOMFORT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ABDOMINALDISCOMFORT **ABDOMINALDISCOMFORT_AFTERTHESECO**

VOMITING_BEFORETHSECONDPOSITIVE

VOMITING_AFTERTHESECONDPOSITIVET

VOMITING_AFTERGLUTENFREEDIETWASS

FREQUENTLOOSESTOOLS_BEFORETHSECO

FREQUENTLOOSESTOOLS_AFTERTHESECO

FREQUENTLOOSESTOOLS_AFTERGLUTENF

CHRONICCONSTIPATION_AFTERGLUTENF

ABDOMINALDISCOMFORT_AFTERGLUTENF

Subject ID: _____

i.e. being gassy, bloated, or complaining of pains			
Poor weight gain	0	0	0
Short stature	0	0	0
Fatigue	0	0	0
Irritability	0	0	0
Dental enamel defects	0	0	0
DENTALENAMALDEFECTS_BEFORETHESEC		DENTALENAMALDEFECTS_AFTERTHESECO	
Skin manifestations	0	0	0
Neurological symptoms	0	0	0
ANEMIA_BEFORETHESECONDPPOSITIVETT		ANEMIA_AFTERTHESECONDPPOSITIVETG	
Anemia	0	0	0
Other _____	0	0	0
OTHER_BEFORETHESECONDPPOSITIVETT		OTHER_AFTERTHESECONDPPOSITIVETG	
ICD-10 Code			

FATIGUE_BEFORETHESECONDPPOSITIVET
 FATIGUE_AFTERTHESECONDPPOSITIVETT
 FATIGUE_AFTERGLUTENFREEDIETWASST
 DENTALENAMALDEFECTS_AFTERGLUTENF
 ANEMIA_AFTERGLUTENFREEDIETWASSTA
 OTHER_AFTERGLUTENFREEDIETWASSTA

NOSYMPTOMSFORCHILD_BEFORETHESECO
 NOSYMPTOMSFORCHILD_AFTERTHESECON
 NOSYMPTOMSFORCHILD_AFTERGLUTENFR

NEUROLOGICALSYMPTOMS_BEFORETHESE
 NEUROLOGICALSYMPTOMS_AFTERTHESECO
 NEUROLOGICALSYMPTOMS_AFTERGLUTEN

IRRITABILITY_BEFORETHESECONDPPOSIT
 IRRITABILITY_AFTERTHESECONDPPOSIT
 IRRITABILITY_AFTERGLUTENFREEDIET

POORWEIGHTGAIN_BEFORETHESECONDP
 POORWEIGHTGAIN_AFTERTHESECONDP
 POORWEIGHTGAIN_AFTERGLUTENFREEDI

SHORTSTATURE_BEFORETHESECONDP
 SHORTSTATURE_AFTERTHESECONDP
 SHORTSTATURE_AFTERGLUTENFREEDIET

SKINIRRITATION_BEFORETHESECONDP
 SKINIRRITATION_AFTERTHESECONDP
 SKINIRRITATION_AFTERGLUTENFREEDI

TEDDY
The Environmental Determinants of Diabetes in the Young

Change in Study Participation

* These fields are required in order to SAVE the form.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Date of Contact	<input type="text"/> <input type="text"/> <input type="text"/> 2012 <input type="text"/> *	Visit Location Code	<input type="text"/> *
TEDDY Staff Code	<input type="text"/> *		

Subject/family does not wish to participate further as of: 2012 * **effective_age**

Who is declining the participation? Parent Child Both

Reason(s) subject/family does not wish to participate further (check all that apply):

1. No reason given

- A. Active Contact Made, subject asked to be withdrawn from study, no reason given
- B. Passive Withdrawal: active contact NOT made, contact information correct, subject not responding to repeated scheduling attempts.

2. Unavailable - moving out of the area

3. Wants to 'wait and see' - will deal with diabetes if it occurs

4. Protocol characteristics

- A. Concerns about blood draw
- B. Concerns about poop samples
- C. Concerns about frequency of visits
- D. Concerns about filling out questionnaires/forms
- E. Protocol too demanding
- F. Duration of study is too long
- G. Doesn't want to be reminded of the child's risk
- H. Transportation difficulties, too far to travel
- I. Worried about privacy/confidentiality
- J. Worried about future loss of insurance
- K. No prevention or treatment is offered
- L. Food diaries too troublesome
- M. Other (specify reason:)

5. Family characteristics

- A. Too busy/not enough time
- B. Feeling overwhelmed/too stressed
- C. Language barrier
- D. Child has other medical or behavioral problems
- E. Parent or other family member has medical or emotional problems
- F. Family members can't agree on whether to participate
- G. Doesn't want to be in research
- H. Subject already in another research study
- I. Family member already in another research study
- J. Family health care provider does not recommend participation
- K. Other (specify reason:)

6. HLA additional genotyping sample result differs from HLA screening result: child is not HLA eligible for the study, family no longer wants to participate

7. TEDDY child no longer wants to participate

Subject lost to follow up as of: 2012

No valid contact information available - lost subject/family contact information

Subject rejoins study as of: 2012

Reason(s) subject/family rejoined study (check all that apply):

- 1. Family member or friend developed diabetes
- 2. A new baby also carries risk alleles; both will continue
- 3. Family moved back to study area
- 4. Life change that makes it possible to participate
- 5. Family/parent changed their mind about participating
- 6. Other (specify reason)

Family has given permission to be contacted again*

Yes No Not asked

PedsQL™
Diabetes Module

Version 3.2

CHILD REPORT (ages 8-12)

DIRECTIONS

Children with diabetes sometimes have special problems. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by selecting:

- 0** if it is **never** a problem
- 1** if it is **almost never** a problem
- 2** if it is **sometimes** a problem
- 3** if it is **often** a problem
- 4** if it is **almost always** a problem

There are no right or wrong answers.
If you do not understand a question, please ask for help.

Date you completed this questionnaire:

□	□	/	□	□	□	/	□	□	□	□
---	---	---	---	---	---	---	---	---	---	---

event_age

(DD/MMM/YYYY - Example 01/JAN/2004)

In the past **ONE month**, how much of a **problem** has this been for you ...

ABOUT MY DIABETES (problems with...)	Never	Almost Never	Some-times	Often	Almost Always	
1. I feel hungry	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IFEELHUNGRY
2. I feel thirsty	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IFEELTHIRSTY
3. I have to go to the bathroom too often	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IHAVETOGOBATHROOMTOOFTEN
4. I have tummy aches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IHAVETUMMYACHES
5. I have headaches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HAVEHEADACHES
6. I feel like I need to throw up	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IFEELLIKEINEEDTOTHROWUP
7. I go "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IGOLOW
8. I go "high"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IGOHIGH
9. I feel tired	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IFEELTIREDD
10. I get shaky	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IGETSHAKY
11. I get sweaty	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IGETSWEATY
12. I feel dizzy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IFEELDIZZY
13. I feel weak	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IFEELWEAK
14. I have trouble sleeping	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IHAVETROUBLESLEEPING
15. I get cranky or grumpy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	IGETCRANKYORGRUMPY

In the past **ONE month**, how much of a **problem** has this been for you ...

TREATMENT - I (problems with...)	Never	Almost Never	Sometimes	Often	Almost Always	
1. It hurts to get my finger pricked	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	ITHURSTOGETMYFINGERPRICKED
2. It hurts to get insulin shots	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	ITHURSTOGETINSULINSHOTS
3. I am embarrassed by my diabetes treatment	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	EMBARRASSEDBYMYDIABETESTREATME
4. My parents and I argue about my diabetes care	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	ARGUEABOUTMYDIABETESCARE
5. It is hard for me to do everything I need to do to care for my diabetes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTODOEVERYTHINGFORDIABETES

Whether you do these things **on your own or with the help of your parents**, please answer how hard these things were to do in the past **ONE month**.

TREATMENT - II (problems with...)	Never	Almost Never	Sometimes	Often	Almost Always	
1. It is hard for me to take blood glucose tests	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTOTAKEBLOODGLUCOSETESTS
2. It is hard for me to take insulin shots	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTOTAKEINSULINSHOTS
3. It is hard for me to play or do sports	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTOPLAYORDOSPORTS
4. It is hard for me to keep track of carbohydrates	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTOKEEPTRACKOFCARBS
5. It is hard for me to carry a fast-acting carbohydrate	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTOCARRYFASTACTINGCARB
6. It is hard for me to snack when I go "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARDTOSNACKWHENLOW

In the past **ONE month**, how much of a **problem** has this been for you ...

WORRY (problems with...)	Never	Almost Never	Sometimes	Often	Almost Always	
1. I worry about going "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	I WORRY ABOUT GOING LOW
2. I worry about going "high"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	I WORRY ABOUT GOING HIGH

In the past **ONE month**, how much of a **problem** has this been for you ...

COMMUNICATION (problems with...)	Never	Almost Never	Sometimes	Often	Almost Always	
1. It is hard for me to tell the doctors and nurses how I feel	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARD TO TELL DOCTORS HOW I FEEL
2. It is hard for me to ask the doctors and nurses questions	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARD TO ASK DOCTORS QUESTIONS
3. It is hard for me to explain my illness to other people	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	HARD TO EXPLAIN ILLNESS
4. I am embarrassed about having diabetes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	EMBARRASSED ABOUT HAVING DIABETES

Local Use Only



12010

SubjectID

Diabetes Management Form

Office Use Only

VISIT

Visit: Baseline 3 Months 6 Months 12 Months 18 Months 24 Months 36 Months

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

--	--	--

Protocol ID:

Date Form Completed:

/ / event_age
 (DD/MMM/YYYY - Example 01/JAN/2004)

Person Completing Form: _____

TEDDY Staff Code of Person Completing Form:

PERSONSINTERVIEWED_MOTHER

PERSONSINTERVIEWED_OTHERPRIMARYC

Person(s) Interviewed: Mother Father Other Primary Caretaker
PERSONSINTERVIEWED_FATHER

PERSONSINTERVIEWED_OTHER

Other, specify _____

PERSONINTERVIEWEDOTHERCODE Code:

--	--	--	--	--	--



12010

Local Use Only

SubjectID

A. GLUCOSE MONITORING

1. Does your child use a Continuous Glucose Monitoring System (CGMS)? Yes No Unknown

GLUCOSEMONITORINGCGMS

2. How many times per day does your child check their blood glucose?

GLUCOSEMONITORINGTIMESCHECK

B. GLUCOSE

Method of data collection for the questions below: Download Paperlog

Date of first recorded blood glucose monitoring for questions below:

 / /

FIRSTRECORDEDBLOODGLUCOSEAGE

Date of last recorded blood glucose monitoring for questions below:

 / /

LASTRECORDEDBLOODGLUCOSEAGE

1. Total number of home blood glucose monitorings per day over last two weeks:

GLUCOSETOTALNUMMONITORINGS

2. Number of total home blood glucose monitorings over last two weeks that were less than 60 mg/dl or less than 3.3 mmol/L:

GLUCOSENUMMONITORINGSLT65

3. Average of all recorded glucoses (over last two weeks):

GLUCOSEAVEALLGLUCOSES

 .

mg/dl mmol/L

GLUCOSEAVEALLGLUCOSESMEASUREME

4. Lowest recorded glucose (over last two weeks):

GLUCOSELOWESTGLUCOSE

 .

mg/dl mmol/L

GLUCOSELOWESTGLUCOSEMEASUREMEN

5. Highest recorded glucose (over last two weeks):

GLUCOSEHIGHESTGLUCOSE

 .

mg/dl mmol/L

GLUCOSEHIGHESTGLUCOSEMEASUREME

6. Once meter is downloaded/log reviewed, calculate the percent of blood glucose levels in target (60-180 mg/dl or 3.3-9.9 mmol/L) over the last two weeks:

PCTBLOODGLUCOSETARGET

 . %

7. Once meter is downloaded/log reviewed, calculate the percent of blood glucose levels that are in the hypoglycemia range (less than 60 mg/dl or less than 3.3 mmol/L) over the last two weeks:

PCTBLOODGLUCOSEHYPOGLYCEMIA

 . %

8. Once meter is downloaded/log reviewed, calculate the percent of blood glucose levels that are in the hyperglycemia range (greater than 180 mg/dl or greater than 9.9 mmol/L) over the last two weeks:

PCTBLOODGLUCOSEHYPERGLYCEMIA

 . %

English Teleform

TEDDY

The Environmental Determinants of Diabetes in the Young

Diagnosis of Diabetes

The following ADA criteria must be met on two occasions (unless criterion 4 is present): At least one plasma, serum or whole blood glucose should be measured in a local laboratory. Hyperglycemia must not be attributable to other causes (e.g. acute stress, exogenous glucocorticoid use).

- 1. Casual (or: Random) (any time of day without regard to time since last meal) plasma glucose ≥ 200 mg/dL (11.1 mmol/L), if accompanied by unequivocal symptoms (i.e. polyuria, polydipsia, polyphagia, and/or weight loss)
- Or
- 2. Fasting (no food or drinks except water for at least 8 hours) plasma glucose ≥ 126 mg/dL (7 mmol/L)
- Or
- 3. 2-hour plasma glucose ≥ 200 mg/dL (11.1 mmol/L) in oral glucose tolerance test (OGTT)
- Or
- 4. Unequivocal hyperglycemia with acute metabolic decompensation (diabetic ketoacidosis).

Unless criterion 4 is present or the fasting glucose is ≥ 250 mg/dL (13.8 mmol/L) at the bedside or in the local laboratory on the day of testing, it is preferred that at least one of the two testing occasions involve an oral glucose tolerance test (OGTT). If the first criterion met is #3, i.e. by the 2-hour OGTT value, the OGTT should be repeated within 60 days. It is essential that every effort be made to obtain the necessary tests to establish the diagnosis of diabetes. Subjects will be instructed to eat a balanced diet and not to do any excessive exercises in the days leading up to the OGTT.

* These fields are required in order to SAVE the form.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

TEDDY Staff Code of person completing form	<input type="text"/>	Visit Location Code	<input type="text"/>
	* Interviewer_id		*
Date form completed	<input type="text"/>	<input type="text"/>	* event_age

Date of Diagnosis of Diabetes by ADA criteria * diagnosisdateage

Diabetes Diagnosis made 3131 DiabetesDiagnosisMade

By TEDDY Study Staff Member TEDDY Staff Code

Elsewhere Location

Do we have signed medical release? 4145 HEIGHTCM Yes No Don't Know DoHaveSignedMedicalRelease

Current Weight kg Height cm Date of measurement:

Signs and/or Symptoms:		
Was the child symptomatic? 3133	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	WasChildSymptomatic
If yes, complete the following:		
Polyuria Polyuria	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 3134	If yes, Date of Onset: <input type="text" value="3135"/> <input type="text" value="3136"/> <input type="text" value="3137"/>
Polydipsia Polydipsia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 3138	If yes, Date of Onset: <input type="text" value="3139"/> <input type="text" value="3140"/> <input type="text" value="3148"/>
Polyphagia Polyphagia	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 3149	If yes, Date of Onset: <input type="text" value="3150"/> <input type="text" value="3151"/> <input type="text" value="3152"/>
Weight Loss WeightLoss	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown 3141	If yes, amount <input type="text" value="3142"/> kg WeightLossAmountkg

Polyuriadateofonsetage
Polydipsiadateofonsetage
Polyphagiadateofonsetage

Glucose Values: Report the glucose values at the two occasions required to establish the diagnosis of diabetes. Meter readings must be supported by at least one diagnostic laboratory sample, drawn at a different time than the meter read sample. For each glucose value, report the following:

Result(mg/dL)	Result (mmol/L)	Date	Hours since last meal	Type	Test	Draw Site
<input type="text" value="3153"/>	<input type="text" value="3154"/>	<input type="text" value="3155"/> <input type="text" value="3156"/> <input type="text" value="3157"/>	<input type="text" value="3158"/>	<input type="radio"/> Meter <input type="radio"/> TEDDY Lab <input type="radio"/> Other Lab	<input type="radio"/> Random Glucose <input type="radio"/> Fasting Glucose <input type="radio"/> Postprandial Glucose <input type="radio"/> OGTT (2 hr value)	<input type="radio"/> Venous Plasma <input type="radio"/> Venous Blood <input type="radio"/> Capillary Blood
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="radio"/> Meter <input type="radio"/> TEDDY Lab <input type="radio"/> Other Lab	<input type="radio"/> Random Glucose <input type="radio"/> Fasting Glucose <input type="radio"/> Postprandial Glucose <input type="radio"/> OGTT (2 hr value)	<input type="radio"/> Venous Plasma <input type="radio"/> Venous Blood <input type="radio"/> Capillary Blood

Glycosylated hemoglobin

HemoglobinA1cResult

Hemoglobin A1c : Result % Date

Normal Range NormalRangeForHemoglobin

- Not Done 3789
 Subject's medical chart not available to TEDDY staff notdoneglucosylatedhemo

Laboratory Values - Report as many of the following as available

Initial Values at time of Diabetes Diagnosis

Date DATEOFINITIALVISITAGE

	Result	Time (Please record time in Universal Time - for example 2 pm would be recorded as 14:00)
pH <input type="radio"/> Venous <input type="radio"/> Arterial <input type="radio"/> Capillary 3166 pH <input type="radio"/> Not Done notdoneforph 3790 <input type="radio"/> Subject's medical chart not available to TEDDY staff	<input type="text" value="3167"/> pHResult	<input type="text" value="3168"/> hr : min pHTime
Bicarbonate/Total CO ₂ 3791 <input type="radio"/> Not Done notdoneforbicarbonate <input type="radio"/> Subject's medical chart not available to TEDDY staff	bicarbonateortotalco2resultmeq <input type="text" value="3169"/> mEq/L <input type="text" value="3170"/> mmol/L bicarbonateortotalco2resultmmo	<input type="text" value="3171"/> hr : min BicarbonateorTotalCO2Time
pCO ₂ 3792 <input type="radio"/> Not Done notdoneforpco2 <input type="radio"/> Subject's medical chart not available to TEDDY staff	<input type="text" value="3172"/> torr <input type="text" value="3445"/> kPa <input type="text" value="3447"/> mmHg pco2resulttorr pco2resultkpa pco2resultmmhg	<input type="text" value="3173"/> hr : min pCO2Time
Base Excess (BE)(value can be positive or negative. If reported as base deficit record as excess using opposite sign) <input type="radio"/> Not Done notdoneforbaseexcess 3794 <input type="radio"/> Subject's medical chart not available to TEDDY staff notdoneforbasedeficit	baseexcessresultmmoll BASEDEFICITRESULTMMOLL baseexcessresultmEq <input type="text" value="3174"/> mEq/L <input type="text" value="3457"/> mmol/L <input type="radio"/> Positive <input type="radio"/> Negative 3456 baseexcess	<input type="text" value="3458"/> hr : min BaseExcessTime BaseDeficitTime
Potassium 3795 <input type="radio"/> Not Done notdoneforpotassium <input type="radio"/> Subject's medical chart not available to TEDDY staff	<input type="text" value="3176"/> mmol/L potassiumresult	<input type="text" value="3177"/> hr : min PotassiumTime
Sodium 3796 <input type="radio"/> Not Done notdoneforsodium <input type="radio"/> Subject's medical chart not available to TEDDY staff	<input type="text" value="3178"/> mmol/L sodiumresult	<input type="text" value="3179"/> hr : min SodiumTime
Chloride 3797 <input type="radio"/> Not Done notdoneforchloride <input type="radio"/> Subject's medical chart not available to TEDDY staff	<input type="text" value="3180"/> mmol/L chlorideresult	<input type="text" value="3181"/> hr : min ChlorideTime
BUN 3798 <input type="radio"/> Not Done notdoneforbun <input type="radio"/> Subject's medical chart not available to TEDDY staff	bunresultmgdl <input type="text" value="3183"/> mg/dL <input type="text" value="3182"/> mmol/L bunresultmmol	buntime <input type="text" value="3184"/> hr : min
Plasma Creatinine 3799 <input type="radio"/> Not Done notdoneforplasmacreat <input type="radio"/> Subject's medical chart not available to TEDDY staff	plasmacreatinineresultmicromol <input type="text" value="3459"/> micromol/L <input type="text" value="4074"/> mg/dL plasmacreatinineresultmgdl	plasmacreatininetime <input type="text" value="3460"/> hr : min
Beta OHB (blood ketone levels) <input type="radio"/> Blood <input type="radio"/> Serum <input type="radio"/> Plasma 3185 <input type="radio"/> Not Done 3800 BetaOHB <input type="radio"/> Subject's medical chart not available to TEDDY staff notdoneforbetaohb	<input type="text" value="3186"/> mg/dL <input type="text" value="3187"/> mmol/L BetaOHBResultmgDL BetaOHBResultmmol L	BetaOHBTime <input type="text" value="3188"/> hr : min
Urine Ketones 3801 <input type="radio"/> Not Done notdoneforurineketones <input type="radio"/> Subject's medical chart not available to TEDDY staff	3189 <input type="radio"/> Negative <input type="radio"/> Trace <input type="radio"/> Small <input type="radio"/> Moderate <input type="radio"/> Large UrineKetonesResult	<input type="text" value="3190"/> hr : min UrineKetonesTime

If laboratory evaluations were not obtained to evaluate for ketoacidosis, please comment on the subject's clinical situation at diagnosis:

NOLABEVALKETOACIDCOMMENT

4075

pH and Bicarbonate Values at time of nadir

pH
 Venous Arterial Capillary 3191
 Not Done *notdoneforphvaluenadir* 3802
 Subject's medical chart not available to TEDDY staff

phresultattimeofnadir

Date of pH result at time of nadir
 Date
 Time hr : min *phattimeofnadir*
pHNadirTime

Bicarbonate
 Not Done 3803
 Subject's medical chart not available to TEDDY staff *notdoneforbicarbvaluenadir*

bicarbonateresultmeqL
 mEq/L mmol/L
bicarbonateresultmmolL

Date
 Time hr : min *bicarbonatettime*

Treatment

Yes No Unknown 3216 *wasthischildhospitalized*
 If yes, name and address of the hospital

If child was hospitalized, list below any additional diagnoses from hospital discharge summary: ICD-10 Codes
 Additionaldiagnoses

 Additionaldiagnosesfromhospita

 Date of admission
dateadmninage
datedischargeage Date of discharge

Yes No Unknown 3219 *wasthischildtreatedinemergency*
 If yes, name and address of the emergency room

 Date of admission
dateofadmissionage
dateofdischargeage Date of discharge

Yes No Unknown 3201 *wasthischildtreatedinoutpatien*
 If yes name and address of clinic

 Date of initial visit
dateofinitialvisitage

Insulin (including insulin drip and/or s.c. insulin)

Has insulin been started? *hasinsulinbeenstarted* Yes No Unknown 3206 *INSULINTHERAPYSTARTDATEAGE*
 Date of starting insulin therapy

Family has given permission to be contacted again* Yes No Not asked 2145

PERMCONTACTAGAIN T1DM DX FOR DCC USE ONLY:

DKA Status not based on pH: *dkastatus*

No DKA (check all that apply) 5243

DKA (check all that apply)

Date of starting insulin therapy

Family has given permission to be contacted again* Yes No Not asked

FOR DCC USE ONLY:

DKA Status not based on pH:

No DKA (check all that apply)

DKA (check all that apply)

Urine ketones negative

Urine ketones trace

Urine ketones small

Blood ketones < 1.5

Asymptomatic/Physician report

Bicarb > 15

Blood ketones >= 1.5

Urine ketones moderate

Urine ketones large

DKANo_Urineketonesnegative

DKANo_Urineketonestrace

DKANo_Urineketonessmall

DKANo_Bloodketones15

DKANo_Bicarb15

DKANo_AsymptomaticPhysicianrepo

DKAStatusPresent_Bloodketones15

DKAStatusPresent_Urineketonesmod

DKAStatusPresent_Urineketoneslar

Per Clinical Implementation Committee this subject does not meet diagnostic criteria for Type 1 Diabetes

Save

Save & Print

Print

Close

Day Care Diet



Date: _____ Child's Name: _____

Weekday (circle one): M T W Th F Sat Sun

Recorded By (Name): _____

Day

What time/ did the child eat?	What did the child, eat/ drink? ★ Use 1 line per food/drink ★ Include vitamins and water	How much did the child eat/drink? ★ Include units (oz., tbs., tsp., cups, etc.)	Brand Name/ Preparation ★ Was anything added? ★ How was the food/drink prepared? ★ If the food was prepared, what were the ingredients? ★ Milk: indicate if breast milk, formula, cow's milk, etc.
_____ am pm Day 1			
_____ am pm Day 2			

TEDDY**The Environmental Determinants of Diabetes in the Young****Enrollment Form**

* These fields are required in order to SAVE the form.

Subject ID		Date of Birth	
Local Code		Date of Registration	.
Status		Clinical Center	CC SHORT

Date of Contact	<input type="text"/> <input type="text"/> 2007 *	Visit Location Code	<input type="text"/> *
TEDDY Staff Code	<input type="text"/> *	<input type="radio"/> Date parent informed of child's increased risk <input type="radio"/> Date letter sent to parents <input type="radio"/> Parents never informed NEVER_INFORMED_FLAG *	
		<input type="text"/>	<input type="text"/> 2007

 Agreed to follow-up, informed consent signed AGREE_FU

 Excluded (select one reason below): EXCLUDED

1. First visit did not occur before the child was 4.5 months.

- A. HLA testing result not known before child was 4.5 months INELIG_CAT1
- B. Appointment not scheduled before child was 4.5 months due to scheduling problem at site INELIG_CAT2
- C. Appointment did not occur within window due to circumstances beyond site's control INELIG_CAT3
- D. Correct contact information is unavailable INELIG_CAT4
- E. Unable to contact: no response to phone calls or messages INELIG_CAT5

 2. Child has an illness or birth defect that precludes long-term follow-up or involves use of treatment that may alter the natural history of diabetes.

ILLBIRTH

Describe ILLBIRTH_DESCR
 3. Refused to have samples stored at Repository. REF_REPOS

 Refusal to enroll (select all that apply below): REF_ENR

4. No reason given REF_CAT1
5. Unavailable - moving out of the area REF_CAT2
6. Wants to 'wait and see' - will deal with diabetes if it occurs; do not think the baby is at risk of developing diabetes REF_CAT3

7. Protocol characteristics

- A. Concerns about blood draw BLOOD
- B. Concerns about poop samples POOP
- C. Concerns about frequency of visits VISITS
- D. Concerns about filling out questionnaires/forms FORMS
- E. Protocol too demanding DEMANDING
- F. Duration of study is too long LONG
- G. Doesn't want to be reminded of the child's risk RISK
- H. Transportation difficulties, too far to travel TRAVEL
- I. Worried about privacy/confidentiality PRIVACY
- J. Worried about future loss of insurance INSURANCE
- K. No prevention or treatment is offered TREATMENT
- L. Food diaries too troublesome FOOD
- M. Other (specify reason:) OTHER_PROTOCOL

 OTHER_PROTOCOL_REASON

8. Family characteristics

- A. Too busy/not enough time TIME
- B. Feeling overwhelmed/too stressed STRESS
- C. Language barrier LANGUAGE
- D. Child has other medical or behavioral problems MEDICAL
- E. Parent or other family member has medical or emotional problems PARENT_MED
- F. Family members can't agree on whether to participate AGREE
- G. Doesn't want to be in research RESEARCH
- H. Subject already in another research study OTHR_RESEARCH
- I. Family member already in another research study FAM_OTHR
- J. Family health care provider does not recommend participation DOCTOR
- K. Other (specify reason:) OTHER_FAMILY

 OTHER_FAMILY_REASON

Family has given permission to be contacted again PERMIT

 Yes No Not asked NOTASKED

English Teleform

Swedish Teleform

German Teleform

Finnish Teleform

Spanish Teleform

TEDDY

The Environmental Determinants of Diabetes in the Young

Family History Questionnaire

* These fields are required in order to SAVE the form.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	
Date Questionnaire Reviewed	<input type="text"/> <input type="text"/> <input type="text"/> *	Visit Location Code	<input type="text"/> *
TEDDY Staff Code	<input type="text"/> *		

This questionnaire asks about your child's family history of diabetes and other autoimmune diseases. For the TEDDY child's parents, grandparents, aunts, uncles and siblings (full and half) please complete the following tables. If you don't know the exact age or year it is okay to estimate. You may want to check records or talk with relatives to get this information.

Relative	Birth year	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
Child's biological mother	MotherBirthYear <input type="text" value="1210"/> <input type="checkbox"/> Unknown 3820	MotherAge Age at death <input type="text" value="1211"/> or Year of death <input type="text" value="1212"/> <input type="checkbox"/> Unknown 3821 MotherDeathYear	<input type="checkbox"/> none or unknown 1213 MotherAutoImmuneDiseaseUnknown ICD-10 (Office use only) <input type="text" value="1214"/> ICD-10 (Office use only) <input type="text" value="1215"/> ICD-10 Codes <input type="text" value="2146"/> Add	MotherDiabetic 1216 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1217 MotherDiabetesType <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	MotherDiabetesDiagAge Age at diagnosis <input type="text" value="1229"/> or Year of diagnosis <input type="text" value="1230"/> <input type="checkbox"/> Unknown 3822 MotherDiabetesDiagYear	1220 MotherTakenInsulinShot <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Child's biological father	FatherBirthYear <input type="text" value="1221"/> <input type="checkbox"/> Unknown 3823	FatherAge Age at death <input type="text" value="1222"/> or Year of death <input type="text" value="1223"/> <input type="checkbox"/> Unknown 3824 FatherDeathYear	<input type="checkbox"/> none or unknown 1224 ICD-10 (Office use only) <input type="text" value="1225"/> ICD-10 (Office use only) <input type="text" value="1226"/> ICD-10 Codes <input type="text" value="2147"/> Add	1227 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	FatherDiabetesType 1228 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1229"/> or Year of diagnosis <input type="text" value="1230"/> <input type="checkbox"/> Unknown 3825	1231 FatherTakenInsulinShot <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Child's maternal grandmother	GrandMotherBirthYear <input type="text" value="1232"/> <input type="checkbox"/> Unknown 3818	Age at death <input type="text" value="1233"/> or Year of death <input type="text" value="1234"/> <input type="checkbox"/> Unknown 3819	<input type="checkbox"/> none or unknown 1235 GrandMomAutoImmDiseaseUnknown ICD-10 (Office use only) <input type="text" value="1236"/> Code1 ICD-10 (Office use only) <input type="text" value="1237"/> ICD-10 Codes <input type="text" value="2148"/> Add	1238 GrandMotherDiabetic <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1239 GrandMotherDiabetesType <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	GrandMotherDiabetesDiagAge Age at diagnosis <input type="text" value="1240"/> or Year of diagnosis <input type="text" value="1241"/> <input type="checkbox"/> Unknown GrandMotherDiabetesDiagYear	1242 GrandMotherTakenInsulinShot <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Relative	Birth year	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
Child's maternal grandfather	1243 <input type="checkbox"/> Unknown 3827	Age at death 1244 or Year of death 1246 <input type="checkbox"/> Unknown 3828	<input type="checkbox"/> none or unknown 1247 ICD-10 (Office use only) 1248 ICD-10 (Office use only) 1249 ICD-10 Codes 2149 Add	1250 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	PaternalGrandMotherDiabetic 1251 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Unknown PatGrandMomDiabetesType	Age at diagnosis 1252 or Year of diagnosis 1253 <input type="checkbox"/> Unknown	1254 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Child's paternal grandmother	1255 <input type="checkbox"/> Unknown 3830	Age at death 1256 or Year of death 1257 <input type="checkbox"/> Unknown 3831	<input type="checkbox"/> none or unknown 1258 ICD-10 (Office use only) 1259 ICD-10 (Office use only) 1260 ICD-10 Codes 2150 Add	1261 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	PaternalGrandMotherDiabetic 1262 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown PatGrandMomDiabetesType	Age at diagnosis 1263 or Year of diagnosis 1264 <input type="checkbox"/> Unknown 3832 PatGrandMomDiabetesDiagAge PatGrandMomDiabetesDiagYr	PatGrandMotherTakeInsulinShot 1265 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Child's paternal grandfather	1266 <input type="checkbox"/> Unknown 3833	Age at death 1267 or Year of death 1268 <input type="checkbox"/> Unknown 3834	<input type="checkbox"/> none or unknown 1269 ICD-10 (Office use only) 1270 ICD-10 (Office use only) 1271 ICD-10 Codes 2151 Add	1272 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	PaternalGrandFatherDiabetic 1273 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Unknown PatGrandFatherDiabetesType	Age at diagnosis 1274 or Year of diagnosis 1275 <input type="checkbox"/> Unknown 3835 PatGrandFatherDiabetesDiagAge PatGrandFatherDiabetesDiagYr	PatGrandFatherTakenInsulinShot 1276 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Child's aunt(s) & uncle(s)	Birth year	Sex	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
1277 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle1	<input type="text" value="1278"/> <input type="checkbox"/> Unknown 3842	<input type="radio"/> Male <input type="radio"/> Female 1279	1282 → AuntUncleAgeDeath1 Age at death <input type="text" value="1280"/> or Year of death <input type="text" value="1281"/> <input type="checkbox"/> Unknown 3843 ChildAuntUncleAgeYrDeathUnkwn3	<input type="checkbox"/> none or unknown ICD - 10 (Office use only) <input type="text" value="1283"/> <input type="checkbox"/> ICD - 10 (Office use only) <input type="text" value="1284"/> ICD - 10 Codes <input type="text" value="2152"/> <input type="button" value="Add"/>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleDiabetic1	1286 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown AuntUncleDiabetesType1	1289 Age at diagnosis <input type="text" value="1287"/> or Year of diagnosis <input type="text" value="1288"/> <input type="checkbox"/> Unknown AuntUncleDiabetesDiagAge1 AuntUncleDiabetesDiagYr1	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleTakenInsulin1
1290 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle2	<input type="text" value="1291"/> <input type="checkbox"/> Unknown 3836	<input type="radio"/> Male <input type="radio"/> Female 1292	1295 AuntUncleAgeDeath2 Age at death <input type="text" value="1293"/> or Year of death <input type="text" value="1294"/> <input type="checkbox"/> Unknown 3837	<input type="checkbox"/> none or unknown ICD - 10 (Office use only) <input type="text" value="1296"/> <input type="checkbox"/> ICD - 10 (Office use only) <input type="text" value="1297"/>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1299 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	1302 Age at diagnosis <input type="text" value="1300"/> or Year of diagnosis <input type="text" value="1301"/> <input type="checkbox"/> Unknown 3838 AuntUncleTakenInsulin2	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1303 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle3	<input type="text" value="1304"/> <input type="checkbox"/> Unknown 3839	<input type="radio"/> Male <input type="radio"/> Female 1305	1308 → AuntUncleSex3 Age at death <input type="text" value="1306"/> or Year of death <input type="text" value="1307"/> <input type="checkbox"/> Unknown 3840 AuntUncleAgeDeath3 AuntUncleDeathYr3	<input type="checkbox"/> none or unknown ICD - 10 (Office use only) <input type="text" value="1309"/> <input type="checkbox"/> ICD - 10 (Office use only) <input type="text" value="1310"/>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleDiabetic3	1312 AuntUncleDiabetesType3 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	1315 Age at diagnosis <input type="text" value="1313"/> or Year of diagnosis <input type="text" value="1314"/> <input type="checkbox"/> Unknown 3841 AuntUncleTakenInsulin3	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

ChildsAuntUncleBirthYr3

ChildAuntUncleBirthYrUnknown3

AuntUncleAutolmmDisUnknown3

AuntUncleAutolmmDisCode13

AuntUncleAutolmmDisCode23

AuntUncleDiabetesDiagAge3

AuntUncleDiabetesDiagYr3

ChildAuntUncAgeYrDiaDiabUnkwn2

Child's aunt(s) & uncle(s)	Birth year	Sex	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
1316 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle4	1317 <input type="checkbox"/> Unknown 3845	1318 <input type="radio"/> Male <input type="radio"/> Female	1321 → <input type="checkbox"/> none or unknown Age at death <input type="text" value="1319"/> or Year of death <input type="text" value="1320"/> <input type="checkbox"/> Unknown 3846	<input type="checkbox"/> none or unknown ICD-10 (Office use only) <input type="text" value="1322"/> <input type="checkbox"/> none or unknown ICD-10 (Office use only) <input type="text" value="1323"/>	1324 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1325 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1326"/> or Year of diagnosis <input type="text" value="1327"/> <input type="checkbox"/> Unknown	1328 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1329 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle5	1330 <input type="checkbox"/> Unknown 3848	1331 <input type="radio"/> Male <input type="radio"/> Female	1334 → <input type="checkbox"/> none or unknown Age at death <input type="text" value="1332"/> or Year of death <input type="text" value="1333"/> <input type="checkbox"/> Unknown 3849	<input type="checkbox"/> none or unknown ICD-10 (Office use only) <input type="text" value="1335"/> <input type="checkbox"/> none or unknown ICD-10 (Office use only) <input type="text" value="1336"/>	1337 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1338 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1339"/> or Year of diagnosis <input type="text" value="1340"/> <input type="checkbox"/> Unknown	1341 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1342 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle6	1343 <input type="checkbox"/> Unknown 3851	1344 <input type="radio"/> Male <input type="radio"/> Female	1347 → <input type="checkbox"/> none or unknown Age at death <input type="text" value="1345"/> or Year of death <input type="text" value="1346"/> <input type="checkbox"/> Unknown 3852	<input type="checkbox"/> none or unknown ICD-10 (Office use only) <input type="text" value="1348"/> <input type="checkbox"/> none or unknown ICD-10 (Office use only) <input type="text" value="1349"/>	1350 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1351 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1352"/> or Year of diagnosis <input type="text" value="1353"/> <input type="checkbox"/> Unknown	1354 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Child's aunt(s) & uncle(s)	Birth year	Sex	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
1355 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle7	<input type="text" value="1356"/> <input type="checkbox"/> Unknown 3854	1357 <input type="radio"/> Male <input type="radio"/> Female	Age at death <input type="text" value="1358"/> or Year of death <input type="text" value="1359"/> <input type="checkbox"/> Unknown 3855	<input type="checkbox"/> none or unknown 1360 ICD - 10 (Office use only) <input type="text" value="1361"/> ICD - 10 (Office use only) <input type="text" value="1362"/>	1363 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1364 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1365"/> or Year of diagnosis <input type="text" value="1366"/> <input type="checkbox"/> Unknown 3856	1367 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1368 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle8	<input type="text" value="1369"/> <input type="checkbox"/> Unknown 3857	1370 <input type="radio"/> Male <input type="radio"/> Female	Age at death <input type="text" value="1371"/> or Year of death <input type="text" value="1372"/> <input type="checkbox"/> Unknown 3858	<input type="checkbox"/> none or unknown 1373 ICD - 10 (Office use only) <input type="text" value="1374"/> ICD - 10 (Office use only) <input type="text" value="1375"/>	1376 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1377 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1378"/> or Year of diagnosis <input type="text" value="1379"/> <input type="checkbox"/> Unknown 3859	1380 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1381 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle9	<input type="text" value="1382"/> <input type="checkbox"/> Unknown 3860	1383 <input type="radio"/> Male <input type="radio"/> Female	Age at death <input type="text" value="1384"/> or Year of death <input type="text" value="1385"/> <input type="checkbox"/> Unknown 3861	<input type="checkbox"/> none or unknown 1386 ICD - 10 (Office use only) <input type="text" value="1387"/> ICD - 10 (Office use only) <input type="text" value="1388"/>	1389 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1390 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1391"/> or Year of diagnosis <input type="text" value="1392"/> <input type="checkbox"/> Unknown 3862	1393 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Aunt(s) & Uncle(s)	BirthYear	Sex	Age at Death OR Year of Death	List autoimmune disease(s) this person has/had	Does or did this person have diabetes?	Diabetes Type	Age at Diagnosis OR Year of Diagnosis	Has this person ever taken insulin shots?
2091 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling	<input type="text" value="2092"/> <input type="checkbox"/> Unknown 3890	2093 <input type="radio"/> Male <input type="radio"/> Female	<input type="text" value="2094"/> <input type="text" value="2095"/> <input type="checkbox"/> Unknown 3891	2096 ↓ <input type="text" value="2097"/> <input type="text" value="2098"/>	2099 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	2100 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	<input type="text" value="2101"/> <input type="text" value="2102"/> <input type="checkbox"/> Unknown 3892	2103 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling	<input type="text" value=""/> Unknown	<input type="radio"/> Male <input type="radio"/> Female	<input type="text" value=""/> <input type="text" value=""/> <input type="checkbox"/> Unknown	<input type="text" value=""/> <input type="text" value=""/>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	<input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	<input type="text" value=""/> <input type="text" value=""/> <input type="checkbox"/> Unknown	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Child's sibling(s)	Birth year	Sex	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
1395 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling1	Sibling1Birthyear Sibling1AuntUncleBirthYrUnknow 1396 <input type="checkbox"/> Unknown 3863	1397 <input type="radio"/> Male <input type="radio"/> Female Sibling1Sex	Age at death 1398 or Year of death 1399 <input type="checkbox"/> Unknown 3864 SiblingAgeDeath1 SiblingDeathYr1 Sibling1AuntUncleAgeYrDeathUnk	<input type="checkbox"/> none or unknown 1400 ICD-10 (Office use only) 1401 ICD-10 (Office use only) 1402 ICD-10 Codes 2153 <input type="button" value="Add"/>	SiblingDiabetic1 1403 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown SiblingAutoImmDiseCode1 Sibling1AutoImmDiseCode2 SiblingsAutoimmuneDiseaseIC1_1	Diabetes type 1404 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown Sibling1DiabetesType	Age at diagnosis 1405 or Year of diagnosis 1406 <input type="checkbox"/> Unknown 3865 Sibling1DiabetesDiagAge Sibling1DiabetesDiagYr Sibling1AuntUncAgeYrDiaDiabUnk	Has this person ever taken insulin shots? 1407 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown Sibling1TakenInsulinShot
1408 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling2	1409 <input type="checkbox"/> Unknown 3866	1410 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1411 or Year of death 1412 <input type="checkbox"/> Unknown 3867	<input type="checkbox"/> none or unknown 1413 ICD-10 (Office use only) 1414 ICD-10 (Office use only) 1415	1416 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1417 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1418 or Year of diagnosis 1419 <input type="checkbox"/> Unknown 3868	1420 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1421 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling3	1422 <input type="checkbox"/> Unknown 3869	1423 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1424 or Year of death 1425 <input type="checkbox"/> Unknown 3870	<input type="checkbox"/> none or unknown 1426 ICD-10 (Office use only) 1427 ICD-10 (Office use only) 1428	1429 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown SiblingDiabetic3	1430 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1431 or Year of diagnosis 1432 <input type="checkbox"/> Unknown 3871	1433 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

SiblingAutoImmDiseUnknown3
 SiblingAutoImmDiseCode3
 Sibling1AutoImmDiseCode2

Sibling3DiabetesDiagAge
 Sibling3DiabetesDiagYr
 Sibling3AuntUncAgeYrDiaDiabUnk

Child's sibling(s)	Birth year	Sex	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
1434 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling4	<input type="text" value="1435"/> <input type="checkbox"/> Unknown 3872	1436 <input type="radio"/> Male <input type="radio"/> Female	Age at death <input type="text" value="1437"/> or Year of death <input type="text" value="1438"/> <input type="checkbox"/> Unknown 3873	<input type="checkbox"/> none or unknown 1439 ICD-10 (Office use only) <input type="text" value="1440"/> ICD-10 (Office use only) <input type="text" value="1441"/>	1442 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1443 <input checked="" type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1444"/> or Year of diagnosis <input type="text" value="1445"/> <input type="checkbox"/> Unknown 3874	1446 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1447 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling5	<input type="text" value="1448"/> <input type="checkbox"/> Unknown 3875	1449 <input type="radio"/> Male <input type="radio"/> Female	Age at death <input type="text" value="1450"/> or Year of death <input type="text" value="1451"/> <input type="checkbox"/> Unknown 3876	<input type="checkbox"/> none or unknown 1452 ICD-10 (Office use only) <input type="text" value="1453"/> ICD-10 (Office use only) <input type="text" value="1454"/>	1455 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1456 <input checked="" type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1457"/> or Year of diagnosis <input type="text" value="1458"/> <input type="checkbox"/> Unknown 3877	1459 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1460 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling6	<input type="text" value="1461"/> <input type="checkbox"/> Unknown 3878	1462 <input type="radio"/> Male <input type="radio"/> Female	Age at death <input type="text" value="1463"/> or Year of death <input type="text" value="1464"/> <input type="checkbox"/> Unknown 3879	<input type="checkbox"/> none or unknown 1465 ICD-10 (Office use only) <input type="text" value="1466"/> ICD-10 (Office use only) <input type="text" value="1467"/>	1468 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1469 <input checked="" type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis <input type="text" value="1470"/> or Year of diagnosis <input type="text" value="1471"/> <input type="checkbox"/> Unknown 3880	1472 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Child's sibling(s)	Birth year	Sex	If person is deceased, please write age or year of death	List autoimmune disease(s) this person has/had (refer to the provided list of diseases)	Does or did this person have diabetes?	Diabetes type	What was the age or year of diagnosis of diabetes?	Has this person ever taken insulin shots?
1473 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling7	1474 <input type="checkbox"/> Unknown 3881	1475 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1476 or Year of death 1477 <input type="checkbox"/> Unknown 3882	<input type="checkbox"/> none or unknown 1478 ICD-10 (Office use only) 1479 ICD-10 (Office use only) 1480	1481 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1482 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1483 or Year of diagnosis 1484 <input type="checkbox"/> Unknown 3883	1485 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1486 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling8	1487 <input type="checkbox"/> Unknown 3884	1488 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1489 or Year of death 1490 <input type="checkbox"/> Unknown 3885	<input type="checkbox"/> none or unknown 1491 ICD-10 (Office use only) 1492 ICD-10 (Office use only) 1493	1494 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1495 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1496 or Year of diagnosis 1497 <input type="checkbox"/> Unknown 3886	1498 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
1499 <input type="radio"/> Full sibling <input type="radio"/> Half sibling ChildsSibling9	1500 <input type="checkbox"/> Unknown 3887	1501 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1502 or Year of death 1503 <input type="checkbox"/> Unknown 3888	<input type="checkbox"/> none or unknown 1504 ICD-10 (Office use only) 1505 ICD-10 (Office use only) 1506	1507 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1508 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1609 or Year of diagnosis 1510 <input type="checkbox"/> Unknown 3889	1511 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Sibling(s)	Birth Year	Sex	Age at Death OR Year of Death	List autoimmune disease(s) this person has/had	Does or did this person have diabetes?	DiabetesType	Age at Diagnosis OR Year of Diagnosis	Has this person ever taken insulin shots?
2104 <input type="radio"/> Full sibling <input type="radio"/> Half sibling	2105 <input type="checkbox"/> Unknown 3893	2106 <input type="radio"/> Male <input type="radio"/> Female	2107 2108 <input type="checkbox"/> Unknown 3894	2109 <input type="checkbox"/> 2110 <input type="checkbox"/> 2111	2112 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	2113 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	2114 2115 <input type="checkbox"/> Unknown 3895	2116 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
<input type="radio"/> Full sibling <input type="radio"/> Half sibling	<input type="checkbox"/> Unknown	<input type="radio"/> Male <input type="radio"/> Female	<input type="checkbox"/> Unknown	<input type="checkbox"/> <input type="checkbox"/>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	<input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unknown	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

TEDDY
The Environmental Determinants of Diabetes in the Young

Save Form Print Form

Close/Refresh Form

Sibling's DNA Sample Collection Form

Tracking System

Subject ID	Local Code	Clinical Center	Visit Location Code	Date of Collection		
				<input checked="" type="checkbox"/> Sample Processed according to standard protocol or Standard protocol followed, Insufficient Volume		
						Today

Use with Long-Distance Protocol Only

Long-Distance Protocol Insufficient Volume

Date sample was processed:	Time sample was processed (this is the time the sample was put in the freezer): * Record time in Universal Time - Eg., 2:00 pm would be recorded as 14:00

Autofill Insufficient Volume/Not Collected

Test Name	Vial Barcode Number	Sample Volume	Box Number	Space Number	Insufficient Volume
Sibling's DNA sample	<input type="checkbox"/> This child is also enrolled in the TEDDY Study, use 48 month non-HLA genotyping sample for this sample <input type="text"/>	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Sibling's antibody sample	<input type="text"/>	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

* These fields are required in order to SAVE the form.

Family ID:

Relative ID:

(Enter or add Relative ID already been assigned for this person. Otherwise, leave blank and Relative ID will be assigned after you save the form.)

1) Sibling's date of birth*

	<input type="text"/>	<input type="text"/>	<input type="text"/>
2) Gender of sibling	<input type="radio"/> Male	<input type="radio"/> Female	
3) Is this a full or half sibling of the TEDDY child?	<input type="radio"/> Full	<input type="radio"/> Half	SIBLING_TYPE_CD
a) If this is a half sibling, which parent do the children share?	<input type="radio"/> Mother	<input type="radio"/> Father	HALF_SIB_COMMON_PARENT_CD
4) Has this child been screened for the TEDDY study or been enrolled in the TEDDY study?	<input type="radio"/> Yes	<input type="radio"/> No	KID_ALSO_ENROLLED_CD
a) If yes, enter TEDDY Subject ID and Local Code of this child below:			
Subject ID:	<input type="text"/>		
Local Code:	<input type="text"/>		
5) Is this child a twin or multiple?	<input type="radio"/> Yes	<input type="radio"/> No	IS_KID_MULTIPLE_CD
If yes:			
a) Are the twins/multiples identical or fraternal?	<input type="radio"/> Identical	<input type="radio"/> Fraternal	<input type="radio"/> Unknown
b) Is this child a twin/multiple of this TEDDY child?	<input type="radio"/> Yes	<input type="radio"/> No	KID_MULTIPLE_THIS_TEDDY_KID_CD
c) If no and DNA sample was collected from his/her twin/multiple enter twin/multiple's vial barcode number below:			
Other twin/multiple's DNA sample vial barcode number:	<input type="text"/>		
Other twin/multiple's DNA sample vial barcode number:	<input type="text"/>		
Other twin/multiple's DNA sample vial barcode number:	<input type="text"/>		
6) Does this child have diabetes?*	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
a) If yes, what is the diabetes type?	<input type="radio"/> Type 1 Diabetes	<input type="radio"/> Type 2 Diabetes	<input type="radio"/> Gestational
	<input type="radio"/> Unknown	DIABETES_TYPE_CD	
b) If yes, what was his/her age at diagnosis or year of diagnosis?			
Age: <input type="text"/>	OR	Year: <input type="text"/>	DIABETES_AGE_DX
c) If yes, has insulin been started?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Date of starting insulin therapy: <input type="text"/>	<input type="text"/>	<input type="text"/>	INSULIN_STARTED_CD
	<input type="text"/>	<input type="text"/>	INSULIN_START_AGE

Instructions

- (1) One 5 mL blood sample will be obtained from each parent and sibling (both full and half siblings) of the TEDDY child for heritability analyses. These samples can be collected at any time during the study.
- (2) Transfer 5.0 mL of blood into a plastic EDTA tube (glass tubes should not be used).
- (3) Mix the contents of the tube gently by turning it up and down five times immediately after sampling. Aliquot the 5.0 mL of blood into a 8.0 mL externally threaded cryovial.
- (4) Choose the visit location code from the drop down menu and enter the Date of Draw (DD/MMM/YYYY) on this form.
- (5) Place cursor in the "Vial Barcode Number" box for the DNA sample.
- (6) Scan the barcode located on the tube.
- (7) In the provided space, enter the sample volume (mL) contained in the tube.
- (8) In the provided space enter box number and space number where the sample will be stored.
- (9) Place the tube in the exact freezer box and space number that you entered on this SCF.
- (10) If an optional antibody sample has been collected: place cursor in the "Vial Barcode Number" box for the antibody sample, scan the barcode located on the tube, enter the sample volume (mL) contained in the tube, enter box number

and space number where the sample will be stored and place the tube in the exact freezer box and space number that you entered on this SCF.

(11) Answer all of the questions pertaining to the relative on the form.

(12) Click the "Save Form" button at the top of this form.

(13) Store the DNA sample at -70°C and send samples in bulk shipments on dry ice to the RNA Reference Lab during your site's scheduled shipment week Store the antibody sample at -70°C at Clinical Center and ship in the next shipment to the Autoantibody Reference Lab.

Form Revision Date: 1 November 2012

TEDDY

The Environmental Determinants of Diabetes in the Young

Save Form

Print Form

Close/Refresh Form

Biological Mother's DNA Sample Collection Form

Tracking System

Subject ID	Local Code	Clinical Center	Visit Location Code	Date of Collection		
				<input type="checkbox"/> Sample Processed according to standard protocol or Standard protocol followed, Insufficient Volume		
						Today

Use with Long-Distance Protocol Only	
<input type="checkbox"/> Long-Distance Protocol Insufficient Volume	
Date sample was processed:	Time sample was processed (this is the time the sample was put in the freezer): * Record time in Universal Time - Eg., 2:00 pm would be recorded as 14:00

<input type="checkbox"/> Autofill Insufficient Volume/Not Collected					
Test Name	Vial Barcode Number	Sample Volume	Box Number	Space Number	Insufficient Volume
Biological mother's DNA sample		<input type="text"/> mL			<input type="checkbox"/>
Biological mother's antibody sample		<input type="text"/> mL			<input type="checkbox"/>

* These fields are required in order to SAVE the form.

Family ID:

Relative ID:

(Enter or edit Relative ID if it has already been assigned for this person. Otherwise, leave blank and Relative ID will be assigned after you save the form.)

1) Biological mother's date of birth*

2) Does the biological mother have other children besides the TEDDY child?* Yes No Unknown HAVE_OTHER_KIDS_CD

a) If yes, by how many different fathers (including the TEDDY child's father) OTHER_KIDS_NUM_PARTNERS

3) Does or did the biological mother have diabetes?* Yes No Unknown HAVE_DIABETES_CD

a) If yes, what is the diabetes type?

Type 1 Diabetes DIABETES_TYPE_CD

Type 2 Diabetes

Gestational

Unknown

b) If yes, what was her age at diagnosis or year of diagnosis?

Age: DIABETES_AGE_DX OR Year: DIABETES_YEAR_DX

c) If yes, has insulin been started? Yes No Unknown INSULIN_STARTED_CD

Date of starting insulin therapy: ▼ INSULIN_START_AGE

Instructions

- (1) One 5 mL blood sample will be obtained from each parent and sibling (both full and half siblings) of the TEDDY child for heritability analyses. These samples can be collected at any time during the study.
- (2) Transfer 5.0 mL of blood into a plastic EDTA tube (glass tubes should not be used).
- (3) Mix the contents of the tube gently by turning it up and down five times immediately after sampling. Aliquot the 5.0 mL of blood into a 8.0 mL externally threaded cryovial.
- (4) Choose the visit location code from the drop down menu and enter the Date of Draw (DD/MMM/YYYY) on this form.
- (5) Place cursor in the "Vial Barcode Number" box for the DNA sample.
- (6) Scan the barcode located on the tube.
- (7) In the provided space, enter the sample volume (mL) contained in the tube.
- (8) In the provided space enter box number and space number where the sample will be stored.
- (9) Place the tube in the exact freezer box and space number that you entered on this SCF.
- (10) If an optional antibody sample has been collected: place cursor in the "Vial Barcode Number" box for the antibody sample, scan the barcode located on the tube, enter the sample volume (mL) contained in the tube, enter box number and space number where the sample will be stored and place the tube in the exact freezer box and space number that you entered on this SCF.
- (11) Answer all of the questions pertaining to the relative on the form.
- (12) Click the "Save Form" button at the top of this form.
- (13) Store the DNA sample at -70°C and send samples in bulk shipments on dry ice to the RNA Reference Lab during your site's scheduled shipment week Store the antibody sample at -70°C at Clinical Center and ship in the next shipment to the Autoantibody Reference Lab.

Form Revision Date: 1 November 2012

TEDDY
The Environmental Determinants of Diabetes in the Young

Save Form Print Form

Close/Refresh Form

Biological Father's DNA Sample Collection Form

Tracking System

Subject ID	Local Code	Clinical Center	Visit Location Code	Date of Collection		
185647	212685	WAS - Pacific Northwest Research Institute		<input type="checkbox"/> Sample Processed according to standard protocol or Standard protocol followed, Insufficient Volume		
						Today

Use with Long-Distance Protocol Only	
<input type="checkbox"/> Long-Distance Protocol Insufficient Volume	
Date sample was processed:	Time sample was processed (this is the time the sample was put in the freezer): * Record time in Universal Time - Eg., 2:00 pm would be recorded as 14:00

<input type="checkbox"/> Autofill Insufficient Volume/Not Collected					
Test Name	Vial Barcode Number	Sample Volume	Box Number	Space Number	Insufficient Volume
Biological father's DNA sample		<input type="text"/> mL			<input type="checkbox"/>
Biological father's antibody sample		<input type="text"/> mL			<input type="checkbox"/>

* These fields are required in order to SAVE the form.

Family ID: **108136**

Relative ID:

(Enter or edit Relative ID if it has already been assigned for this person. Otherwise, leave blank and Relative ID will be assigned after you save the form.)

1) Biological father's date of birth*

2) Does the biological father have other children besides the TEDDY child?*

Yes No Unknown HAVE_OTHER_KIDS_CD

a) If yes, by how many different mothers (including the TEDDY child's mother) OTHER_KIDS_NUM_PARTNERS

3) Does the biological father have diabetes?*

Yes No Unknown HAVE_DIABETES_CD

a) If yes, what is the diabetes type?

Type 1 Diabetes

Type 2 Diabetes DIABETES_TYPE_CD

Unknown

b) If yes, what was his age at diagnosis or year of diagnosis?

Age: DIABETES_AGE_DX OR Year: DIABETES_YEAR_DX

c) If yes, has insulin been started?

Yes No Unknown INSULIN_STARTED_CD

Date of starting insulin therapy: INSULIN_START_AGE

Instructions

- (1) One 5 mL blood sample will be obtained from each parent and sibling (both full and half siblings) of the TEDDY child for heritability analyses. These samples can be collected at any time during the study.
- (2) Transfer 5.0 mL of blood into a plastic EDTA tube (glass tubes should not be used).
- (3) Mix the contents of the tube gently by turning it up and down five times immediately after sampling. Aliquot the 5.0 mL of blood into a 8.0 mL externally threaded cryovial.
- (4) Choose the visit location code from the drop down menu and enter the Date of Draw (DD/MMM/YYYY) on this form.
- (5) Place cursor in the "Vial Barcode Number" box for the DNA sample.
- (6) Scan the barcode located on the tube.
- (7) In the provided space, enter the sample volume (mL) contained in the tube.
- (8) In the provided space enter box number and space number where the sample will be stored.
- (9) Place the tube in the exact freezer box and space number that you entered on this SCF.
- (10) If an optional antibody sample has been collected: place cursor in the "Vial Barcode Number" box for the antibody sample, scan the barcode located on the tube, enter the sample volume (mL) contained in the tube, enter box number and space number where the sample will be stored and place the tube in the exact freezer box and space number that you entered on this SCF.
- (11) Answer all of the questions pertaining to the relative on the form.
- (12) Click the "Save Form" button at the top of this form.
- (13) Store the DNA sample at -70°C and send samples in bulk shipments on dry ice to the RNA Reference Lab during your site's scheduled shipment week Store the antibody sample at -70°C at Clinical Center and ship in the next shipment to the Autoantibody Reference Lab.

Form Revision Date: 1 November 2012

- English Teleform
- German Teleform
- Swedish Teleform
- Finnish Teleform
- Spanish Teleform

TEDDY
The Environmental Determinants of Diabetes in the Young

First TEDDY Study Questionnaire
(Father)

* These fields are required in order to SAVE the form.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Date Form was Reviewed	<input type="text" value="53"/> <input type="text" value="54"/> <input type="text" value="55"/> *	Visit Location Code	<input type="text" value="ital"/> *
TEDDY Staff Code	<input type="text"/> *		

formreviewedage

1. Date you completed this questionnaire: *

We are interested in your reactions to your baby's genetic test result and your experience in the TEDDY study

18 **2. Compared to other children, do you think your child's risk for developing diabetes is:** ChildsRiskForDiabetes
 (Mark one answer)
 Much Lower Somewhat lower About the same Somewhat higher Much higher

19 **3. When you think about your baby's future, do you think:** (Mark one answer) BabysFutureDoYouThink
 The child will develop diabetes in the near future
 The child will eventually develop diabetes but a long time from now
 The child will never develop diabetes
 You're unsure what will happen

20 **4. When you think about your baby's risk for developing diabetes do you feel:** (Mark one answer on each line a-f)
 21 a. Not at all calm Somewhat calm Moderately calm Very calm BabysRiskDiabetesFeelCalm
 22 b. Not at all worried Somewhat worried Moderately worried Very worried BabysRiskDiabetesFeelWorried
 23 c. Not at all relaxed Somewhat relaxed Moderately relaxed Very relaxed BabysRiskDiabetesFeelRelaxed
 24 d. Not at all tense Somewhat tense Moderately tense Very tense BabysRiskDiabetesFeelTense
 25 e. Not at all at-ease Somewhat at-ease Moderately at-ease Very at-ease BabysRiskDiabetesFeelAtEase
 26 f. Not at all nervous Somewhat nervous Moderately nervous Very nervous BabysRiskDiabetesFeelNervous

26 **5. Overall, how do you feel having your baby genetically tested for diabetes risk?** BabysGeneticTestDiabetesFeelin
 Liked it a lot Liked it a little It was OK Disliked it a little Disliked it a lot

27 **6. Do you think having the baby genetically tested was a good decision?** BabyGeneticTestGoodDecision
 A great decision A good decision An OK decision A bad decision A very bad decision

28 **7. If a friend's wife was pregnant, would you recommend they have their baby genetically tested for diabetes risk?** RecommendGeneticTestFriends
 No Yes Maybe

- Save
- Save & Print
- Clear
- Close



49511

Local Use Only

SubjectID

TEDDY Study



First Child Questionnaire

© 1970 Charles D. Spielberger All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com This instrument was modified – by: Suzanne Bennett Johnson, Ph.D., Florida State College of Medicine -- from the original.



49511

Local Use Only

SubjectID

Date you answered these questions: _____
(if you need help with the date, please ask your parent)

By now you may have read the TEDDY Junior Scientists books. Just like you, Will and Emma are helping the TEDDY scientists understand why some kids get diabetes and others do not. The last book was called Will and Emma Meet the TEDDY Scientists. In the story, Will and Emma went to the TEDDY lab where they went on an exciting trip inside the body and learned a lot about the TEDDY study, genes, cells, and diabetes. We want to know what you think about that book.

1. Did you read the book, Will and Emma Meet the TEDDY Scientists? (Pick one answer)

1 DID YOU READ THE BOOK

<input type="radio"/> No. I got the book but I did not read it. (Please skip to question 4 on the next page)
<input type="radio"/> No. I did not get the book. (Please skip to question 4 on the next page)
<input type="radio"/> Yes. I read <u>part</u> of the book. (Please go to question 2 below)
<input type="radio"/> Yes. I read <u>all</u> of the book. (Please go to question 2 below)

2. How was the book, Will and Emma Meet the TEDDY Scientists? (Pick one answer)

2 HOW WAS THE BOOK

<input type="radio"/> I liked it a lot.	<input type="radio"/> It was OK.	<input type="radio"/> I did not like it at all.
---	----------------------------------	---

3. Did the book Will and Emma Meet the TEDDY Scientists help you understand what TEDDY is about? (Pick one answer)

3 DID THE BOOK HELP YOU UNDERSTAND

<input type="radio"/> It helped me <u>a lot</u> to understand what TEDDY is about.
<input type="radio"/> It helped me <u>a little</u> to understand what TEDDY is about.
<input type="radio"/> It <u>did not help</u> me understand what TEDDY is about.



49511

Local Use Only

SubjectID

4. Risk is the chance that something may or may not happen. What do you think about your risk of getting diabetes? (Pick one answer)

I think I have . . . _4WHATDOYOUTHINKABOUTYOURRISKO

<input type="radio"/> a smaller risk of getting diabetes than my friends who are not in TEDDY.
<input type="radio"/> the same risk of getting diabetes as my friends who are not in TEDDY.
<input type="radio"/> a higher risk of getting diabetes than my friends who are not in TEDDY.
<input type="radio"/> I am not sure about my risk of getting diabetes.

5. Do you worry about getting diabetes? (Pick one answer) _5DOYOUWORRYABOUTGETTINGDIABET

<input type="radio"/> I never worry.	<input type="radio"/> I worry sometimes.	<input type="radio"/> I worry a lot.
--------------------------------------	--	--------------------------------------

6. Please answer the next questions about how you feel. There are no right or wrong answers. If you do not understand a question, you may skip that question and go on to the next one.

When you think about your risk of getting diabetes, how do you feel? (Pick one answer on each line a – f)

a. I feel	<input type="radio"/> Very worried	<input type="radio"/> Worried <u>_6IFEELWORRIED</u>	<input type="radio"/> Not worried
b. I feel	<input type="radio"/> Very frightened	<input type="radio"/> Frightened <u>_6KIFEELFRIGHTENED</u>	<input type="radio"/> Not frightened
c. I feel	<input type="radio"/> Very happy	<input type="radio"/> Happy <u>_6LIFEELHAPPY</u>	<input type="radio"/> Not happy
d. I feel	<input type="radio"/> Very good	<input type="radio"/> Good <u>_6NIFEELGOOD</u>	<input type="radio"/> Not good
e. I feel	<input type="radio"/> Very troubled	<input type="radio"/> Troubled <u>_6OIFEELTROUBLED</u>	<input type="radio"/> Not troubled
f. I feel	<input type="radio"/> Very nice	<input type="radio"/> Nice <u>_6QIFEELNICE</u>	<input type="radio"/> Not nice

© 1970 Charles D. Spielberger All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com This instrument was modified – by: Suzanne Bennett Johnson, Ph.D., Florida State College of Medicine -- from the original.



49511

Local Use Only

SubjectID

Some families do things they think might stop kids from getting diabetes. Some families do not do these things.

7. Do you do things you think might stop you from getting diabetes? **_7DOYOUODOINGSYOUTHINKMIGHTST**

<input type="radio"/> No
<input type="radio"/> Yes <i>If Yes, what do you do?</i> _7CHILDBSTOPDIABETESYESCOMMENT <hr/> <hr/> <hr/>
Code (office use only) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

8. Do your parents do things they think might stop you from getting diabetes? **_8DOYOURPARENTSDOTHINGSTHEYTHI**

<input type="radio"/> No
<input type="radio"/> Yes <i>If Yes, what do they do?</i> _8PARENTSTOPDIABETESYESCOMMENT <hr/> <hr/> <hr/>
Code (office use only) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="radio"/> I don't know



49511

Local Use Only

SubjectID

9. How do you feel about being in the TEDDY study? (Pick one answer) **_9HOWDOYOUFEELABOUTBEINGINTHET**

<input type="radio"/> I like it a lot.	<input type="radio"/> It is OK.	<input type="radio"/> I do not like it at all.
--	---------------------------------	--

10. How do you feel about your parents' decision that you should be in TEDDY? (Pick one answer) **_10HOWDOYOUFEELABOUTYOURPARENT**

<input type="radio"/> It was a good decision.	<input type="radio"/> It was an okay decision.	<input type="radio"/> It was a bad decision.
---	--	--

11. If you had a friend who was asked to be in a study like TEDDY would you tell them they should do it? (Pick one answer) **_11IFYOUHADAFRIENDWHOWASASKEDT**

<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Maybe
--------------------------	---------------------------	-----------------------------

Thank you very much for your time.



49511

Local Use Only

SubjectID

Office Use Only

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Date Child Completed Questionnaire:

(DD/MMM/YYYY - Example 01/JAN/2004)

Date Questionnaire was Reviewed:

(DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

Tracking form: Gluten-free Diet Annual Update Form

* These fields are required in order to SAVE the form.
* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	
Date of Interview	<input type="text"/> <input type="text"/> <input type="text"/> *	Visit Location Code	<input type="text"/> *
Visit Months	<input type="text"/> 4176 months OR <input type="text"/> 4177 years	TEDDY Staff Code of Interviewer	<input type="text"/> *
Visit Years			

At the next visit after diagnosis of Celiac disease via biopsy (regardless of whether the diagnosis occurred within or outside of the TEDDY Study), after start of gluten-free diet after TGA testing without biopsy or if the child has persistent* positive Transglutaminase antibodies, and every annual visit thereafter, the Gluten-free Diet Annual Update Form will be completed.

***Persistent is defined as having two consecutive TGA positive samples at any time.**

4178

1. Is your child currently on a gluten-free diet?

Yes No Don't Know

Isyourchildcurrentlyonaglutenf

Confirm start/stop dates on Special Diet section of TEDDY extraction form.

4180

2. In the last year, has your child received gluten-free diet counseling from a dietician?

Yes No Don't Know

Hasreceivedglutenfreedietcouns

4093

3. Is your child currently on a **strict** gluten-free diet (free from wheat, rye, barley)?

Yes No Don't Know

childCurrentlyGFD

4094

4. Does your child's diet contain oats?

Yes No Don't Know

childscurrentdietcontainsoats

4095

5. How often does your child consume food containing gluten (choose one option)?

- Never
 Less than once per month
 About once per month
 Several times a month
 Several times a week
 Nearly every day
 Don't know

childconsumefoodcontainingglut

- English Teleform
- German Teleform
- Swedish Teleform
- Finnish Teleform
- Spanish Teleform

TEDDY
The Environmental Determinants of Diabetes in the Young

TEDDY Last Questionnaire

* These fields are required in order to SAVE the form.
 * These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status	Enrolled (Withdrawn) (Diabetic)	Clinical Center	
QUESTIONNAIREREVIEWFDAGE			
Date Form was Reviewed	<input type="text"/> / <input type="text"/> / <input type="text"/> *	Visit Location Code	<input type="text"/> *
TEDDY Staff Code	<input type="text"/> *		
Form Status 2166			
QuestionnaireFormStatus			
<input checked="" type="radio"/> Sent out but not returned <input type="radio"/> Returned but not filled out <input type="radio"/> Unable to contact (no correct address, unable to deliver mail) <input type="radio"/> Not sent out			

1. Date you completed this questionnaire:		<input type="text"/> / <input type="text"/> / <input type="text"/> *	* event_age
2. What is your relationship to the TEDDY child?		2036 RelationToChild_	
<input checked="" type="checkbox"/> Mother <input checked="" type="checkbox"/> Father <input type="checkbox"/> Other Primary <input checked="" type="checkbox"/> Other		Mother Father OtherPrimary Other	
Code <input type="text" value="2071"/>		RelationToChldOtherCode	
3. Who decided that this child would be in the TEDDY study?		2037 PersonDecidingTeddyC_	
<input checked="" type="checkbox"/> I decided <input checked="" type="checkbox"/> My spouse <input checked="" type="checkbox"/> The child's doctor <input checked="" type="checkbox"/> Other (who?)		Idecided MySpouse TheChildsdo OtherWho	
Other <input type="text" value="2117"/>		Code <input type="text" value="2072"/> PersonChildInTeddyOtherCode	
4. Was there anyone in the family who did NOT want this child to be in the TEDDY study?			
<input checked="" type="radio"/> No <input type="radio"/> Yes 2038			
If Yes , who in the family did NOT want the child to be in the study? 2039			
WhoDidNotWantChildIn_			
<input checked="" type="checkbox"/> I did not want the child in the study <input checked="" type="checkbox"/> My spouse did not want the child in the study <input checked="" type="checkbox"/> The child's grandparents did not want the child in the study <input checked="" type="checkbox"/> Other(who?)			
IDidNotWant MySpousedid Thechildsgp Otherwho			
Other <input type="text" value="2118"/>		Code <input type="text" value="2073"/> NotWantingChildInTeddyCode	
5. For your family, was the decision for this child to be in TEDDY:			
<input checked="" type="radio"/> Very easy <input type="radio"/> Easy <input type="radio"/> Both easy and hard <input type="radio"/> Hard <input type="radio"/> Very hard			
DifficultyForFamilyChildInTedd			
6. Listed below are some of the things you were asked to do as part of TEDDY. Please mark how difficult each part of the study was for you.			
Coming into the study center every 3 months	2041	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudyComingToCenter
Having blood drawn from the child	2042	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudyHavingChildsBlood
Keeping records of what the child eats	2043	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudyRecordsOfChildsFood
Keeping the child's records in the TEDDY book	2044	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudyRecordsInTEDDYBook
Sending in the child's stool or poop samples	2045	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartStudySendingChildsStoolSam
Filling out questionnaires	2046	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudyFillingQuestionair
Spending time on TEDDY tasks	2081	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudySpendingTimeOnTeddy
Something else - tell us	2048	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all	PartOfStudyTellUsSomethingElse
Code <input type="text" value="2077"/>		2047	
THINGSDONEASPARTOFTEDDYCODE			

7. Listed below are some of the things you were asked to do as part of TEDDY. Please mark whether you would be willing to be in another study where you would be asked to do the same thing.

Would you be willing to be in another study where you

Have the child's genes tested for diabetes risk	2049	<input checked="" type="radio"/> No <input type="radio"/> Yes	HaveChildsGenesTestedDiabetes
Come into the study center every 3 months	2050	<input checked="" type="radio"/> No <input type="radio"/> Yes	YouComeIntoCenterEvery3mon
Have blood drawn from the child	2051	<input checked="" type="radio"/> No <input type="radio"/> Yes	HaveBloodDrawnFromTheChild
Keep records of what the child eats	2052	<input checked="" type="radio"/> No <input type="radio"/> Yes	KeepRecordsOfWhatChildEats
Keep the child's records in a TEDDY book	2053	<input checked="" type="radio"/> No <input type="radio"/> Yes	KeepChildsRecordsInTEDDYBook
Send in the child's stool or poop samples	2054	<input checked="" type="radio"/> No <input type="radio"/> Yes	SendInChildsStoolSamples
Fill out questionnaires	2055	<input checked="" type="radio"/> No <input type="radio"/> Yes	FillOutQuestionnaires
Spend about the same amount of time on study tasks	2082	<input checked="" type="radio"/> No <input type="radio"/> Yes	SpendSameTimeOnStudyTasks

8. What was the worst part of the study? 2056

- Learning the child was at-risk for getting diabetes
- Coming into the study center every 3 months WorstPartOfStudy
- Having blood drawn from the child
- Getting the child's Autoantibody Results every 3 months
- Keeping records of what the child eats
- Keeping the child's records in the TEDDY book
- Sending in the child's stool or poop samples
- Filling out questionnaires
- Spending time on TEDDY tasks
- Nothing to prevent diabetes was offered as part of the study
- Worrying about the child getting diabetes
- Worrying about possible loss of future health insurance for the child
- Worries about the confidentiality of privacy of the child's study information
- Other (tell us)

other WorstPartOfStudyOther Code WorstPartOfStudyOtherCode

9. What was the best part of the study? 2057

- Learning the child was at-risk for getting diabetes
- Coming into the study center every 3 months
- Having blood drawn from the child
- Getting the child's Autoantibody Results every 3 months BestPartOfStudy
- Keeping records of what the child eats
- Keeping the child's records in the TEDDY book
- Sending in the child's stool or poop samples
- Filling out questionnaires
- Spending time on TEDDY tasks
- Knowing someone was watching the child to see if the child was getting diabetes
- Knowing the child might be able to participate in future diabetes prevention trials
- Knowing that the child's study information will be kept private and confidential
- Other (tell us)

Other BestPartOfStudyOther Code BestPartOfStudyOtherCode

2058

10. Even though we do not know how to prevent diabetes, people sometimes do things to try to stop their child from getting diabetes. Have you done anything to try and stop the child from getting diabetes?

No Yes **AnythingToStopChildFromDiabete**

If **Yes**, check any of the things listed below that you did to try to stop the child from getting diabetes.

Introduced solid foods, such as baby food, table food, or cereal, earlier than you had planned **ThingsDidToStopChildIntroduced1**

Introduced solid foods, such as baby food, table food, or cereal, later than you had planned **ThingsDidToStopChildIntroduced2**

Breastfed child longer **ThingsDidToStopChild_Breastfedch**

Delayed introduction of cow's milk or infant formula based on cow's milk **DidToStopChild_Delayedintr**

Limited child's intake of cow's milk or infant formula based on cow's milk **ThingsDidToStopChild_Limitedchil**

Avoided cow's milk altogether or infant formula based on cow's milk **ThingsDidToStopChild_Avoidedcows**

Avoided or limited child's intake of candy, cookies, cake and other sweet foods **ThingsDidToStopChild_Avoidedor1**

Avoided or limited child's intake of soda or sweet drinks **ThingsDidToStopChild_Avoidedor2**

Gave child diet soda or sugar free drinks **ThingsDidToStopChild_Gavechilddi**

Gave child more juice **ThingsDidToStopChild_Gavechildmo**

Gave child less juice **ThingsDidToStopChild_Gavechildle**

2059

Fed child more often **ThingsDidToStopChild_Fedchildmor**

Fed child less often **ThingsDidToStopChild_Fedchildles**

Made sure child gained enough weight **ThingsDidToStopChild_Madesurech1**

Made sure child was NOT overweight **ThingsDidToStopChild_Madesurech2**

Avoided food additives **ThingsDidToStopChild_Avoidedfood**

Encouraged child to be very active **ThingsDidToStopChild_Encouragedc**

Made sure child did not get overtired **ThingsDidToStopChild_Madesurech3**

Made sure child got plenty of rest **ThingsDidToStopChild_Madesurech4**

Tried to avoid stressful situations **ThingsDidToStopChild_Triedtoavoi**

Gave child vitamins **ThingsDidToStopChild_Gavechildvi**

Gave child insulin shots **ThingsDidToStopChild_Gavechildin**

Gave child herbal supplements **ThingsDidToStopChild_Gavechildhe**

Gave child nicotinamide **ThingsDidToStopChild_Gavechildni**

Tried extra hard to protect child from germs **ThingsDidToStopChild_Triedextrah**

Avoided places where child might be exposed to germs (e.g. day care) **ThingsDidToStopChild_Avoidedplac**

Delayed immunizations **ThingsDidToStopChild_Delayedimmu**

Refused all immunizations **ThingsDidToStopChild_Refusedalli**

Took child to the doctor more often **ThingsDidToStopChild_Tookchildto**

Prayed **ThingsDidToStopChild_Prayed**

Other (tell us) **ThingsDidToStopChild_Othertellus**

Other Code **AnythingToStopChildDiabCode**

2063

11. Overall, how do you feel about having this child participate in the TEDDY study? **FeelingAboutChildsParticipatio**

Liked it a lot Liked it a little It was OK Disliked it a little Disliked it a lot

2064

12. Do you think this child's participation in the TEDDY study was a good decision? **DecisionAboutChildsParticipati**

A great decision A good decision An ok decision A bad decision A very bad decision

2065

13. Would you recommend the TEDDY study to a friend?

No Yes Maybe **RecommendTeddyStudyToFriend**

3295

14. What was the main reason for leaving the TEDDY study?

My child got diabetes

My child was found not to have the high risk genes **ReasonForLeavingTeddyStudy**

Moving out of the TEDDY area

Other (please do not give more than two reasons)

Don't want to answer

Other Code **OtherReasonForleavingstudyCode**

Other Code **OtherReasonForleavingstudyCode2**

Other Codes

OtherDynCodeReasonLeaveStud1_1

OtherDynCodeReasonLeaveStud2_1

2119

15. May we contact you in the future?

No Yes **ContactInFuture**

2066

16. Below, please tell us anything else you would like us to know about your experience with TEDDY.

YourExperienceWithTeddy

Local Use Only



46603

SubjectID

MMTT Procedure Form

Office Use Only

Visit: Baseline 3 Months 6 Months 12 Months 18 Months 24 Months 36 Months

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

--	--	--

Protocol ID:

Date of Procedure:

		/				/			
--	--	---	--	--	--	---	--	--	--

event_age

(DD/MMM/YYYY - Example 01/JAN/2004)

Person Completing Form: _____

TEDDY Staff Code:

--	--	--	--



46603

Local Use Only

SubjectID

1. Do you have milk allergies? **MilkAllergy**

No **(IF NO, PROCEED WITH MMTT)**

Yes **(IF YES, DO NOT PROCEED WITH MMTT; DETERMINE IF THE SUBJECT CAN DRINK BOOST OR NOT; CONSULT WITH MEDICAL OFFICIAL IF NECESSARY)**

2. Have you had anything to eat or drink, besides water, in the last 8 hours? **EatOrDrink**

No

Yes

IF THE SUBJECT CONSUMED ANY FOOD OR DRINK OTHER THAN WATER WITHIN 8 HOURS, RESCHEDULE THE MMTT.

3. Is the subject on an insulin pump? **InsulinPump**

No

Yes



46603

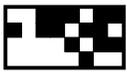
Local Use Only

SubjectID

4. Have you taken any insulin injection or bolus in pump in the last 6 hours? Basal dose in pump will be continued. **InsulinInjectionBolus**

- No (If NO, go to question 5)
- Yes (If YES, ask which insulins were taken; fill in the circle next to the appropriate list of insulins below and follow the corresponding instructions)
- WhichInsulins**

<input type="radio"/>	Detemir Glargine Humulin N Lantus Levemir Novolin N NPH Protaphane Insulatard	Acceptable - continue with MMTT	
<input type="radio"/>	Humulin R Humulin 50/50 Humulin 70/30 Novolin R Novolin 70/30 Regular Actrapid	Time insulin or bolus in pump was taken: <div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute </div> (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)	NOT acceptable if taken within 6 hours of the MMTT - reschedule the MMTT. HumulinRHr HumulinRMin
<input type="radio"/>	Novorapid Apidra Glulisine Humalog Humalog mix 50/50 Humalog mix 75/25 Novolog Novolog mix 70/30 (by injection or bolus per pump)	Time insulin or bolus in pump was taken: <div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute </div> (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)	NOT acceptable if taken within 4 hours of the MMTT - reschedule the MMTT. NovorapidHr NovorapidMin



46603

Local Use Only

SubjectID

5. Have you taken any other diabetes medications in the last 8 hours? **OthDiabetesMed**

NOTE: All medications, other than insulin, should also be documented on the study's Medical History Form. Insulin medication taken for diabetes should be indicated on the Diabetes Management Form.

- No
- Yes

If YES, please specify:

1) OthDiabetesMedSpec1

Code:

OthDiabetesMedCode1

Time medication #1 was taken:

OthDiabetesMedTime1Hr
OthDiabetesMedTime1Min

:
Hour Minute

(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)

2) OthDiabetesMedSpec2

Code:

OthDiabetesMedCode2

Time medication #2 was taken:

OthDiabetesMedTime2Hr
OthDiabetesMedTime2Min

:
Hour Minute

(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)

3) OthDiabetesMedSpec3

Code:

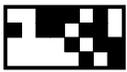
OthDiabetesMedCode3

Time medication #3 was taken:

OthDiabetesMedTime3Hr
OthDiabetesMedTime3Min

:
Hour Minute

(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)



46603

Local Use Only

SubjectID

6. Blood glucose reading prior to -10 minute timepoint (fingerstick)

mg/dL OR neg10minTimepointmgdL

. mmol/L neg10minTimepointmmolL

For Sweden only:

Hemocue 1: neg10minTimepointHemocue1

. mmol/L

Hemocue 2: neg10minTimepointHemocue2

. mmol/L

If blood glucose <60 mg/dL or >250 mg/dL or <3.3 mmol/L or >13.9 mmol/L reschedule MMTT

weight

mLBoostMeal

7. Subject's Weight: . kg x 6mL = mL of Boost High Protein meal

NOTE Boost High Protein meal dose cannot exceed 360 mL.

8. Did the Subject consume all of the Boost High Protein meal? ConsumeAllBoostMeal

No

If NO, estimate the percent of the Boost High Protein meal consumed: BoostMealpct

< 50%

50 – 75%

>75%

Yes



46603

Local Use Only

SubjectID

Sample and Meal Timepoints	Time	Missed Sample
-10 (baseline) minutes c-peptide sample <i>baselineCPepSampleHr</i> <i>baselineCPepSampleMin</i>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<div style="text-align: center;"> <input type="radio"/> Missed sample <i>baselineCPepSampleMissed</i> </div>
-10 (baseline) minutes glucose sample <i>baselineGluSampleHr</i> <i>baselineGluSampleMin</i>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<div style="text-align: center;"> <input type="radio"/> Missed sample <i>baselineGluSampleMissed</i> </div>
0 minutes c-peptide sample <i>_0minCPepSampleHr</i> <i>_0minCPepSampleMin</i>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<div style="text-align: center;"> <input type="radio"/> Missed sample <i>_0minCPepSampleMissed</i> </div>
0 minutes glucose sample <i>_0minGluSampleHr</i> <i>_0minGluSampleMin</i>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<div style="text-align: center;"> <input type="radio"/> Missed sample <i>_0minGluSampleMissed</i> </div>
Start time of meal administration <i>Note: Meal should be consumed within 5 minutes</i>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<div style="text-align: center;"> <i>StartMealHr</i> <i>StartMealMin</i> </div>
If meal consumption time >5 minutes from "0" minutes - indicate time consumed 75% of meal	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<div style="text-align: center;"> <i>Consumed75pctMealHr</i> <i>Consumed75pctMealMin</i> </div>



46603

Local Use Only

SubjectID

15 minutes c-peptide sample <u>_15minCPepSampleHr</u> <u>_15minCPepSampleMin</u>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<input type="radio"/> Missed sample <u>_15minCPepSampleMissed</u>
15 minutes glucose sample <u>_15minGluSampleHr</u> <u>_15minGluSampleMin</u>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<input type="radio"/> Missed sample <u>_15minGluSamplemissed</u>
30 minutes c-peptide sample <u>_30minCPepSampleHr</u> <u>_30minCPepSampleMin</u>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<input type="radio"/> Missed sample <u>_30minCPepSampleMissed</u>
30 minutes glucose sample <u>_30minGluSampleHr</u> <u>_30minGluSampleMin</u>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<input type="radio"/> Missed sample <u>_30minGluSampleMissed</u>
60 minutes c-peptide sample <u>_60minCPepSampleHr</u> <u>_60minCPepSampleMin</u>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<input type="radio"/> Missed sample <u>_60minCPepSampleMissed</u>
60 minutes glucose sample <u>_60minGluSampleHr</u> <u>_60minGluSampleMin</u>	<div style="text-align: center;"> <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00) </div>	<input type="radio"/> Missed sample <u>_60minGluSampleMissed</u>



46603

Local Use Only

SubjectID

<p>90 minutes c-peptide sample <u>_90minCPepSampleHr</u> <u>_90minCPepSampleMin</u></p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample <u>_90minCPepSampleMissed</u></p>
<p>90 minutes glucose sample <u>_90minGluSampleHr</u> <u>_90minGluSampleMin</u></p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample <u>_90minGluSampleMissed</u></p>
<p>120 minutes c-peptide sample <u>_120minCPepSampleHr</u> <u>_120minCPepSampleMin</u></p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample <u>_120minCPepSampleMissed</u></p>
<p>120 minutes glucose sample <u>_120minGluSampleHr</u> <u>_120minGluSampleMin</u></p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> Hour Minute (Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample <u>_120minGluSampleMissed</u></p>



46603

Local Use Only

SubjectID

9a. Blood glucose reading at 120 minute timepoint

mg/dL OR _120minTmepointmgdL

. mmol/L _120minTmepointmmolL

For Sweden only:

Hemocue 1: _120minTmepointHemocue1

. mmol/L

Hemocue 2: _120minTmepointHemocue2

. mmol/L

If glucose is > 250 mg/dL or 13.9 mmol/L perform blood ketones check and record in # 9b.

9b. Beta OHB (Blood ketone levels):

. mg/dL OR BetaOHBmgdL

. mmol/L BetaOHBmmolL

If blood ketones are > 0.6 mmol/L OR blood glucose is >400 mg/dL or 22.2 mmol/L the PI or one of the co-investigators needs to be notified.

Give meal insulin dose after MMTT with snack/meal.



10. Were any of the following symptoms observed or reported by the Subject during the visit? **SymptomsObserv**

- No
- Yes

If YES, mark all that apply:

- Abdominal pain **SymptomsObservwhich_Abdominalpai**
- Diaphoresis (excessive sweating) **SymptomsObservwhich_Diaphoresise**
- Lightheadedness **SymptomsObservwhich_Lightheadedn**
- Nausea and or vomiting **SymptomsObservwhich_Nauseaandorv**
- Seizure **SymptomsObservwhich_Seizure**
- Tremors or trembling **SymptomsObservwhich_Tremorsortre**
- Loss of consciousness due to low blood glucose **SymptomsObservwhich_Lossofconsc1**
- Loss of consciousness due to phlebotomy (fainting) **SymptomsObservwhich_Lossofconsc2**
- Blood glucose is < 45 mg/dL or 2.5 mmol/L **SymptomsObservwhich_Bloodglucos1**
- Blood glucose is > 300 mg/dL or 16.7 mmol/L with ketones >1.5 mmol/L **SymptomsObservw
high_Bloodglucos2**
- Blood glucose is > 500 mg/dL or 27.8 mmol/L with or without ketones **SymptomsObservw
high_Bloodglucos3**
- Other (specify):

SymptomsObservwhich_Otherspecify 1) **SymptomsOth1** _____

ICD-10 Code: .

SymptomsOthCode1

2) **SymptomsOth2** _____

ICD-10 Code: .

SymptomsOthCode2

3) **SymptomsOth3** _____

ICD-10 Code: .

SymptomsOthCode3

11. Comments?

- No
- Yes

If YES, describe below:

CommentsDescribe

English Teleform	German Teleform	Swedish Teleform	Finnish Teleform	Spanish Teleform
------------------	-----------------	------------------	------------------	------------------

TEDDY
The Environmental Determinants of Diabetes in the Young

First TEDDY Study Questionnaire
(Mother)

* These fields are required in order to SAVE the form.
 * These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

DayFormReviewed	<input type="text"/> <input type="text"/> <input type="text"/> *	Visit Location Code	<input type="text"/> *
TEDDY Staff Code	<input type="text"/> *		

1. Date you completed this questionnaire: * EVENT_AGE

Questions 2-17 relate to your latest pregnancy, when you were pregnant with the child in TEDDY.

2. When you were pregnant, did you have any of the illnesses/conditions listed below?*

117	a. Influenza ("flu") or bad cold IIIConditionFluBadCold	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
118	b. Sore throat, tonsillitis, strep throat IIIConditionSorethroat	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
119	c. Bronchitis IIIConditionBronchitis	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
120	d. Genital herpes IIIConditionGenitalHerpes	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
121	e. Cold sores IIIConditionColdSore	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
122	f. Pneumonia IIIConditionPneumonia	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
123	g. Sinus infection IIIConditionSinus	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
124	h. Ear infection IIIConditionEarInfection	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
125	i. Diarrhea or gastroenteritis IllnessDiarrheaGastroenteritis	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
126	j. Skin infection or rash IIIConditionSkinInfection	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
127	k. Kidney, bladder or urinary tract infection KidneyBladderUrinaryInfection	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
128	l. Other infection or fever IIIConditionOtherInfectionFeve	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
129	m. Yellow skin (jaundice) IIIConditionYellowSkinJaundice	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
130	n. High blood pressure IIIConditionHighBP	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
131	o. Swelling of the face and/or hands ConditionFaceHandSwelling	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
132	p. Anemia (low iron in the blood) IIIConditionAnemia	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
133	q. Severe morning sickness (for which you needed medical attention, such as intravenous nutrients) IIIConditionMorningSickness	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
134	r. Other: ICD-10 Code <input type="text" value="136"/> More ICD-10 Codes IIIInnessConditionOther <input type="text" value="188"/> <input type="text"/> <input type="button" value="Add"/>	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know

3. When you were pregnant, did you have any of the following conditions?*

137	a. Pre-eclampsia or toxemia	ConditionPreEclampsiaToxemia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
138	b. Incompetent cervix	ConditionIncompetentCervix	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
139	c. Spotting or bleeding	ConditionSpottingBleeding	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
140	d. Placenta previa (placenta preceded the baby)	PlacentaPrecededTheBaby	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
141	e. Abruptio placenta, or abruption (placenta separated from uterine wall)	ConditionPlacentaAbruption	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
142	f. Premature rupture of the membranes (your water broke before labor started)	MembranePrematureRupture	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
143	g. Prolonged labor (labor for more than 24 hours)	ConditionProlongedLabor	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
144	h. Sciatica (pinched nerve)	ConditionPinchedNerve	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know
145	i. Premature labor (labor started before 37 weeks gestation)	ConditionPrematureLabor	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't Know

146	4. Did you have gestational diabetes?*	<input type="radio"/> No <input type="radio"/> No, but I had an increased sugar level, or impaired glucose tolerance <input type="radio"/> Yes <input type="radio"/> Was not tested for gestational diabetes <input type="radio"/> Don't know
	YesNoHadGestationalDiabetes	
	If you had gestational diabetes:	
	a. During which week of pregnancy was it diagnosed?	<input type="text" value="147"/> week GestationalDiabetesDiagWeek
148	b. How was it treated? (Mark all that apply)	<input checked="" type="checkbox"/> Diet <input checked="" type="checkbox"/> Pills <input checked="" type="checkbox"/> Insulin <input checked="" type="checkbox"/> No treatment DiabetesTreatMethodB_Diet_Pills_Insulin_NoTreatment
	c. What was your average or last HbA1c during pregnancy?	Average <input type="text" value="149"/> % <input checked="" type="checkbox"/> Don't know Last <input type="text" value="150"/> % 151 AvgHbA1cGestational_LastHbA1cGestationalDuringPreg_AvgLastHbA1cDontKnowGestational
152	d. Have you had gestational diabetes during previous pregnancies?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> This was my first pregnancy <input type="radio"/> Was not tested for gestational diabetes PrevPregGestationalDiabetes

153	5. Do you have Type 1 or Type 2 diabetes?* <i>diabetesType</i>	<input checked="" type="radio"/> No <input type="radio"/> Yes, Type 1 <input type="radio"/> Yes, Type 2 <input type="radio"/> Don't know
	a. If yes, how old were you when your diabetes was diagnosed?	<input type="text" value="154"/> <i>AgeWhenDiagDiabetes</i>
155	b. How was your diabetes treated before pregnancy? (Mark all that apply) <i>DiabetesTreatMethodB</i>	<input checked="" type="checkbox"/> Diet <input checked="" type="checkbox"/> Pills <input checked="" type="checkbox"/> Insulin <input checked="" type="checkbox"/> No treatment
156	c. How was your diabetes treated during pregnancy? (Mark all that apply) <i>DiabetesTreatMethodD</i>	<input checked="" type="checkbox"/> Diet <input checked="" type="checkbox"/> Pills <input checked="" type="checkbox"/> Insulin <input checked="" type="checkbox"/> No treatment
157	d. How is your diabetes treated now? (Mark all that apply) <i>DiabetesTreatMethodN</i>	<input checked="" type="checkbox"/> Diet <input checked="" type="checkbox"/> Pills <input checked="" type="checkbox"/> Insulin <input checked="" type="checkbox"/> No treatment
	e. What was your last HbA1c? <i>DiabetesLastHbA1c</i>	<input type="text" value="158"/> % <input checked="" type="checkbox"/> Don't know <i>DiabetesLastHbA1cDontknow</i>
160	6. Do you have a Rh negative blood type?*	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know <i>RhNegativeBloodTypeYesNo</i>
161	a. If you do have a Rh negative blood type, did you get a shot or injection (anti-Rh treatment) for this?	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know <i>IfRhNegativeGotShotInjection</i>
162	b. If you did get a shot or injection, when did you get the shot or injection? <i>ShotInjectionPeriod</i>	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> During pregnancy <input type="checkbox"/> After delivery
163	7. Did you get any vaccines during pregnancy?*	<input checked="" type="radio"/> No <input type="radio"/> Yes <i>VaccinesPregTimeYesNo</i>
	If Yes, please mark which vaccines and during which trimester:	
164	Flu Shot <i>FluShotWhichTrimester</i>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester
165	Tetanus <i>TetanusShotWhichTrimester</i>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester
166	Other_What? Code <input type="text" value="168"/> <i>OtherShotInjectionCode</i>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester
	Other Codes	Trimester
	<input type="text" value="1940"/>	<input checked="" type="checkbox"/> First Trimester <input checked="" type="checkbox"/> Second Trimester <input checked="" type="checkbox"/> Third Trimester <i>OtherVaccCode</i>
	<input type="text" value="1941"/>	<input checked="" type="checkbox"/> First Trimester <input checked="" type="checkbox"/> Second Trimester <input checked="" type="checkbox"/> Third Trimester <i>OtherVaccTrimester</i>
	<input type="text"/>	

324 **8. Did you take any medications during pregnancy?***

No Yes

MedicationDuringPregYesNo

652 **a. Antibiotics. Please list the name of the antibiotic(s) you took.** AntibioticsConsumed

Name of Antibiotic	Code
1942	170

AntibioticName1_1
DuringPregAntibioticCode1_1

653 **b. Anti-inflammatory steroid pills or injections, such as prednisone, cortisone, dexamethasone (often used for asthma, arthritis, autoimmunity, chronic rash).** AntiInflammatoryPillsConsumed

Name of the medication: 1943 Code: 317

Name of Medication	Code
1975	1976

AntiInfSteroidName
Antiinflammatorymedicationc1_1

654 **c. Medication against morning sickness** MedicationMorningSickness

Name of the medication: 1944 Code: 319

Name of Medication	Code
1977	1978

MedAgainstMornSickness
Morningsicknessmedicationco1_1

655 **d. Medication for diabetes** MedicationTakenDiabetes

Name of the medication: 1945 Code: 321 MedForDiabetesName

Name of Medication	Code
1979	1980

PregDiabetesMedicationCode
Diabetesmedicationname1_1

656 **e. Other** OtherMedication

Name of the medication: 1946 Code: 323 OtherMed1

Name of the medication: 1947 Code: 689 OtherMedicationCode1

Name of Medication	Code
1981	1982

OtherMed2
OtherMedicationCode2

9. How often did you smoke during pregnancy?*			
	Not at all	On average, 1 or less per day	If more than one a day, please write the average number of cigarettes you smoked per day during that trimester.
673	First Trimester (months 1-3)	<input checked="" type="radio"/> SmokeFreq1Trimester <input type="radio"/>	<input type="text" value="676"/> SmokeNumCigs1Trimester
674	Second Trimester (months 4-6)	<input checked="" type="radio"/> SmokeFreq2Trimester <input type="radio"/>	<input type="text" value="677"/> SmokeNumCigs2Trimester
675	Third Trimester (months 7-9)	<input checked="" type="radio"/> SmokeFreq3Trimester <input type="radio"/>	<input type="text" value="678"/> SmokeNumCigs3Trimester

10. While you were pregnant did you work outside the home?*			
	Not at all	Part-time	Full-time
181	First Trimester (months 1-3)	<input checked="" type="radio"/> WorkType1Trimester <input type="radio"/>	<input type="radio"/>
182	Second Trimester (months 4-6)	<input checked="" type="radio"/> WorkType2Trimester <input type="radio"/>	<input type="radio"/>
183	Third Trimester (months 7-9)	<input checked="" type="radio"/> WorkType3Trimester <input type="radio"/>	<input type="radio"/>

Please complete the table below by answering questions 11a and 11b for each trimester of your pregnancy.

11a. How often did you drink alcohol during your pregnancy?*

	Not at all	Less than once/month	1-3 times a month	1-2 times a week	3 or more times/week
679 First Trimester (months 1-3)	<input checked="" type="radio"/> AlcoholFreq1Trimester	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
680 Second Trimester (months 4-6)	<input checked="" type="radio"/> AlcoholFreq2Trimester	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
681 Third Trimester (months 7-9)	<input checked="" type="radio"/> AlcoholFreq3Trimester	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11b. How many drinks did you have each time, on average?* (1 drink = 1 beer, 1 glass of wine, or 1 shot of liquor)

	None	Less than 1 drink	1-2 drinks	3-4 drinks	More than 4 drinks
682 First Trimester (months 1-3)	<input checked="" type="radio"/> AlcoholNumDrinks1Trimester	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
683 Second Trimester (months 4-6)	<input checked="" type="radio"/> AlcoholNumDrinks2Trimester	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
684 Third Trimester (months 7-9)	<input checked="" type="radio"/> AlcoholNumDrinks3Trimester	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Please complete the following table which asks about special diets you may have been on during this pregnancy.*

You may mark 'Yes' to more than one type of special diet.

During this pregnancy were you on a :

195	a. Lactose-free diet ? OnLactoseFreeDietYesNo	<input type="radio"/> No <input type="radio"/> Yes
196	b. Diet for diabetes ? OnDietForDiabetesYesNo	<input type="radio"/> No <input type="radio"/> Yes
197	c. Gluten-free diet? OnGlutenFreeDietYesNo	<input type="radio"/> No <input type="radio"/> Yes
198	d. Cow's milk avoidance diet due to cow's milk allergy? CowMilkAvoidanceAllergy	<input type="radio"/> No <input type="radio"/> Yes
199	e. Fish avoidance diet due to fish allergy? FishAvoidanceAllergy	<input type="radio"/> No <input type="radio"/> Yes
200	f. Wheat avoidance diet due to wheat allergy? WheatAvoidanceAllergy	<input type="radio"/> No <input type="radio"/> Yes
201	g. Vegetarian diet ? If yes, please indicate the types of foods you ate on this vegetarian diet - mark all that apply OnVegetarianDietYesNo	<input type="radio"/> No <input type="radio"/> Yes
202	1. Plant products PlantProductsYesNo	<input type="radio"/> No <input type="radio"/> Yes
203	2. Milk and milk products MilkAndMilkPdtsYesNo	<input type="radio"/> No <input type="radio"/> Yes
204	3. Eggs VegDietEggYesNo	<input type="radio"/> No <input type="radio"/> Yes
205	4. Fish VegDietFishYesNo	<input type="radio"/> No <input type="radio"/> Yes
206	h. Different type of special diet ? If yes, please describe the diet (For example: "high protein/low carbohydrate")	<input checked="" type="checkbox"/> No

Code	Yes	
<input type="text" value="208"/>	<input checked="" type="checkbox"/>	209
<input type="text"/>	<input checked="" type="checkbox"/>	
<input type="text"/>	<input checked="" type="checkbox"/>	
<input type="button" value="Add"/>		

SpecialDiet
SpecialDietCode
SpecialdietYes

SpecialdietYes1_1
 SpecialdietYes2_1
 SpecialdietYes3_1
 SpecialdietYes4_1

*SpecialDietCode1_1
 *SpecialDietCode2_1
 *SpecialDietCode3_1
 *SpecialDietCode4_1

13. During your pregnancy, how many glasses of water (8 oz) did you drink per day at home, on average? (Include drinks that you make with water like coffee, tea, juice, powdered milk, etc.)

Water that you drank at home:

City/town of home: _____ Zipcode _____

City	ZipCode
<input type="text" value="1921"/>	<input type="text" value="1922"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Source of water:	Number of glasses per day	Was water filtered?
Tap water from the city/town GlassesPerDayCityTownTapWater	<input type="text" value="212"/>	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know FilteredCityTapWaterYesNo
Tap water from own well or spring GlassesPerDayWellTapWater	<input type="text" value="213"/>	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know TapWaterWellFilteredYesNo
Tap water but do not know the source TapWaterUnknownFilteredYesNo	<input type="text" value="696"/>	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know TapWaterUnknownFilteredYesNo
Bottled water from the store GlassesPerDayStoreBottledWater	<input type="text" value="214"/>	
I don't know the source GlassesPerDayDontKnowSource	<input type="text" value="215"/>	TapWaterUnknownNumGlassesTaken

690

691

692

14. On the next several pages we ask you about what kinds of foods you ate during the last month of your most recent pregnancy, when you were pregnant with the TEDDY child.*

a. Each row should either get a number (for number of times) or a mark in the "Never" box	Serving size	Never	# of times per month	# of times per week	# of times per day
--	--------------	-------	----------------------	---------------------	--------------------

a. Breads, cereals, pastas and bakery products Intake during the last month of your pregnancy

		Never	# of times per month	# of times per week	# of times per day
1. Bread (white, dark, crisp, whole wheat, mixed grain, french, parisien, toast), flour tortillas, bagels or rolls.	1 slice or 1 piece	<input checked="" type="checkbox"/> 216	<input type="text" value="217"/>	<input type="text" value="218"/>	<input type="text" value="219"/>
2. Spaghetti, macaroni, or other type of pasta	1 serving	<input checked="" type="checkbox"/> 220	<input type="text" value="221"/>	<input type="text" value="222"/>	<input type="text" value="223"/>
3. Sweet rolls, pies, shortcakes, muffins, rusk, pastries, doughnuts, cakes, pancakes, waffles	1 slice or 1 piece	<input checked="" type="checkbox"/> 224	<input type="text" value="225"/>	<input type="text" value="226"/>	<input type="text" value="227"/>
4. Cookies, biscotti, biscuits, crackers	2 pieces	<input checked="" type="checkbox"/> 228	<input type="text" value="229"/>	<input type="text" value="230"/>	<input type="text" value="231"/>
5. Pizza	1 slice	<input checked="" type="checkbox"/> 232	<input type="text" value="233"/>	<input type="text" value="234"/>	<input type="text" value="235"/>
6. Meat pot pies or meat pastries	1 piece	<input checked="" type="checkbox"/> 236	<input type="text" value="237"/>	<input type="text" value="238"/>	<input type="text" value="239"/>
7. Breakfast cereals or granola made with wheat, barley or rye	1 bowl, plateful	<input checked="" type="checkbox"/> 240	<input type="text" value="241"/>	<input type="text" value="242"/>	<input type="text" value="243"/>
8. Oatmeal or granola made with oats	1 bowl	<input checked="" type="checkbox"/> 244	<input type="text" value="245"/>	<input type="text" value="246"/>	<input type="text" value="247"/>
9. Rice cereals, cooked rice or rice pudding, rice drink	1 cup	<input checked="" type="checkbox"/> 248	<input type="text" value="249"/>	<input type="text" value="250"/>	<input type="text" value="251"/>
10. Corn and corn-products (Corn bread, polenta, corn cereal, corn tortillas)	1 slice, piece, bowlful	<input checked="" type="checkbox"/> 252	<input type="text" value="253"/>	<input type="text" value="254"/>	<input type="text" value="255"/>
11. Wheat germ, bran, seeds	1 tbsp	<input checked="" type="checkbox"/> 256	<input type="text" value="257"/>	<input type="text" value="258"/>	<input type="text" value="259"/>
12. Buckwheat, millet, kasha	1 cup	<input checked="" type="checkbox"/> 260	<input type="text" value="261"/>	<input type="text" value="262"/>	<input type="text" value="263"/>
13. Other cereal products Code <input type="text" value="265"/>	<input type="radio"/> 1 bowl <input type="radio"/> 1 cup <input type="radio"/> 1 tbsp <input type="radio"/> 1 piece		<input type="text" value="267"/>	<input type="text" value="268"/>	<input type="text" value="269"/>

Other Codes	Serving size	# of times per month	# of times per week	# of times per Day
<input type="radio"/> 1 bowl	1949		<input type="text" value="1950"/>	<input type="text" value="1951"/>
<input type="radio"/> 1 cup		<input type="text" value="1948"/>		<input type="text" value="1952"/>
<input type="radio"/> 1 tbsp				
<input type="radio"/> 1 piece				
<input type="radio"/> 1 bowl		<input type="text" value="1948"/>	<input type="text" value="1950"/>	<input type="text" value="1952"/>
<input type="radio"/> 1 cup				
<input type="radio"/> 1 tbsp				
<input type="radio"/> 1 piece				

b. Each row should either get a number (for number of times) or a mark in the "Never" box	Serving size	Never	# of times per month	# of times per week	# of times per day
b. Cow's milk and cow's milk products (Do not include Soy products here)					
1. Milk (include milk used in breakfast cereals)	1 glass	<input checked="" type="checkbox"/> 345	346	347	348
2. Milk / Cream in coffee or tea	1 tbsp	<input checked="" type="checkbox"/> 349	350	351	352
3. Sour milk, buttermilk	1 glass	<input checked="" type="checkbox"/> 353	354	355	356
4. Yogurt, cultured milk, kefir	1 serving	<input checked="" type="checkbox"/> 357	358	359	360
5. Cottage cheese, curd, quark	1 serving	<input checked="" type="checkbox"/> 361	362	363	364
6. Milk-based puddings, custards, desserts	1 serving	<input checked="" type="checkbox"/> 365	366	367	368
7. Whipped cream (e.g. topping on cakes and other desserts)	2 tbsp	<input checked="" type="checkbox"/> 369	370	371	372
8. Ice cream, frozen yogurt	1 cone or 1 scoop	<input checked="" type="checkbox"/> 373	374	375	376
9. All types of cheese	2 slices or pieces	<input checked="" type="checkbox"/> 377	378	379	380
10. Soups made with milk, cream soups	1 bowl	<input checked="" type="checkbox"/> 381	382	383	384
11. Casseroles and dishes containing cheese (e.g. pizza, lasagna, macaroni and cheese, etc.)	1 serving	<input checked="" type="checkbox"/> 385	386	387	388
12. Other foods prepared with milk or cheese: Code <input type="text" value="390"/>	<input checked="" type="radio"/> 1 glass <input type="radio"/> 1 tbsp <input type="radio"/> 1 serving <input type="radio"/> 1 bowl <input type="radio"/> 1 piece		392	393	394
<div style="display: flex; justify-content: space-between;"> OtherMilkCheeseFoodCode OtherMilkCheeseFoodServingSize OtherMilkCheeseFoodTimesPerDay OtherMilkCheeseFoodTimesPerMon OtherMilkCheeseFoodTimesPerWee </div>					
Other Codes	Serving size	# of times per month	# of times per week	# of times per Day	
<input type="radio"/> 1 glass	1954		OtherMilkFoodweekly	OtherMilkFoodDaily	
<input type="radio"/> 1 tbsp		OtherMilkFoodMonthly			
<input type="text" value="1953"/>	<input type="radio"/> 1 serving	1955	1956	1957	
<input type="radio"/> 1 bowl					
<input type="radio"/> 1 piece					
<input checked="" type="radio"/> 1 glass					
<input type="radio"/> 1 tbsp					
<input type="text" value=""/>	<input type="radio"/> 1 serving	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	
<input type="radio"/> 1 bowl					
<input type="radio"/> 1 piece					
<input type="text" value=""/>					
c. Soy and Soy Products					
1. Soy-based foods (soybeans, soy milk, soy cheese, tofu, miso, soy protein bars, veggie burgers)	1 serving	<input checked="" type="checkbox"/> 1524	1525	1526	1527

d. Each row should either get a number (for number of times) or a mark in the "Never" box	Serving size	Never	# of times per month	# of times per week	# of times per day																				
d. Fish and Fish Dishes																									
1. Pickled Herring, smoked Herring (kippers), or Anchovies	4 slices or pieces	<input checked="" type="checkbox"/> 270	271	272	273																				
2. Canned Tuna or canned Sardines	1 serving	<input checked="" type="checkbox"/> 274	275	276	277																				
3. Fish sticks, fish fingers, fish burgers, or fish fry	1 serving	<input checked="" type="checkbox"/> 278	279	280	281																				
4. Casseroles, soups, pizza, pasta dishes, made of salmon, Mackerel, Bluefish, Trout, Char, Anchovies, or Herring	1 serving	<input checked="" type="checkbox"/> 282	283	284	285																				
5. Casseroles, soups, pizza, pasta dishes made of fish not listed in number 4	1 serving	<input checked="" type="checkbox"/> 286	287	288	289																				
6. Salmon, Mackerel, Bluefish, Trout or Char (e.g. broiled, baked, smoked, fried, not in casseroles, soups, pizza nor pasta dishes)	1 serving	<input checked="" type="checkbox"/> 290	291	292	293																				
7. Bass, Halibut, Pollock, Redfish, or Tuna (e.g. broiled, baked, smoked, fried, not in casseroles, soups, pizza nor pasta dishes)	1 serving	<input checked="" type="checkbox"/> 294	295	296	297																				
8. Carp, Cod, Mahi-Mahi, Sea bass, Haddock, Mullet, Perch, Pike, Sole, Swordfish, Tilapia, Flounder, Grouper, Catfish, Orange Roughly, and Snapper (e.g. broiled, baked, smoked, fried, not in casseroles, soups, pizza nor pasta dishes)	1 serving	<input type="checkbox"/> 298	299	300	301																				
9. Clam chowder, seafood bisque, oyster stew, etc.	1 bowl	<input checked="" type="checkbox"/> 302	303	304	305																				
10. Shrimp, Scallops, Clams, Oysters, Mussels, Crabmeat, Lobster, or other shellfish	1 serving	<input checked="" type="checkbox"/> 306	307	308	309																				
11. Other dishes with fish Code <input type="text" value="311"/> OtherFishDishCode	<input checked="" type="radio"/> 1 piece 312 <input type="radio"/> 1 serving <input type="radio"/> 1 bowl		<input type="text" value="313"/>	<input type="text" value="314"/>	<input type="text" value="315"/>																				
<table border="1"> <thead> <tr> <th data-bbox="196 949 375 987">Other Codes</th> <th data-bbox="375 949 545 987">Serving size</th> <th data-bbox="545 949 846 987"># of times per month</th> <th data-bbox="846 949 1122 987"># of times per week</th> <th data-bbox="1122 949 1403 987"># of times per Day</th> </tr> </thead> <tbody> <tr> <td data-bbox="196 987 375 1071"><input type="text" value="1958"/></td> <td data-bbox="375 987 545 1071"> <input checked="" type="radio"/> 1 piece 1959 <input type="radio"/> 1 serving <input type="radio"/> 1 bowl </td> <td data-bbox="545 987 846 1071"><input type="text" value="1960"/></td> <td data-bbox="846 987 1122 1071"><input type="text" value="1961"/></td> <td data-bbox="1122 987 1403 1071"><input type="text" value="1962"/></td> </tr> <tr> <td data-bbox="196 1071 375 1155"><input type="text" value=""/></td> <td data-bbox="375 1071 545 1155"> <input checked="" type="radio"/> 1 piece <input type="radio"/> 1 serving <input type="radio"/> 1 bowl </td> <td data-bbox="545 1071 846 1155"><input type="text" value=""/></td> <td data-bbox="846 1071 1122 1155"><input type="text" value=""/></td> <td data-bbox="1122 1071 1403 1155"><input type="text" value=""/></td> </tr> <tr> <td data-bbox="196 1155 375 1293"><input type="text" value=""/></td> <td data-bbox="375 1155 545 1293">OtherFishFoodServSize</td> <td data-bbox="545 1155 846 1293"></td> <td data-bbox="846 1155 1122 1293"></td> <td data-bbox="1122 1155 1403 1293"></td> </tr> </tbody> </table>						Other Codes	Serving size	# of times per month	# of times per week	# of times per Day	<input type="text" value="1958"/>	<input checked="" type="radio"/> 1 piece 1959 <input type="radio"/> 1 serving <input type="radio"/> 1 bowl	<input type="text" value="1960"/>	<input type="text" value="1961"/>	<input type="text" value="1962"/>	<input type="text" value=""/>	<input checked="" type="radio"/> 1 piece <input type="radio"/> 1 serving <input type="radio"/> 1 bowl	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	OtherFishFoodServSize			
Other Codes	Serving size	# of times per month	# of times per week	# of times per Day																					
<input type="text" value="1958"/>	<input checked="" type="radio"/> 1 piece 1959 <input type="radio"/> 1 serving <input type="radio"/> 1 bowl	<input type="text" value="1960"/>	<input type="text" value="1961"/>	<input type="text" value="1962"/>																					
<input type="text" value=""/>	<input checked="" type="radio"/> 1 piece <input type="radio"/> 1 serving <input type="radio"/> 1 bowl	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>																					
<input type="text" value=""/>	OtherFishFoodServSize																								

343

15. During your pregnancy did you take any dietary supplements such as prenatal vitamins, single vitamins, multivitamins, multiminerals, or other dietary supplements (such as fish oils, antioxidants or others)?

No Yes

pregmultivitaminsconsume yesno

Type of preparation, Brand name:Code	tablet(s)	mL(s)	Other	Other Code	How many times a week?	Intermittent / Unknown frequency	Which weeks?	Entire pregnancy
327	1514	1515	1517	1516	328	<input checked="" type="checkbox"/> 2139	329 - 330	<input checked="" type="checkbox"/> 331
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>
						<input checked="" type="checkbox"/>	-	<input checked="" type="checkbox"/>

- 327 - dietarysuppcode
- 1514 - dietarysupplementtablets
- 1515 - dietarysuppinmilliliters
- 1517 - otherdietarysupp2
- 1516 - dietarysuppcodeother
- 328 - dietarysupplementtimesperwe
- 2139 - dietarysuppunknownfrequency
- 329 - dietarysuppstartweekpreg
- 330 - dietarysuppendweekpreg
- 331 - dietarysuppentirepreg

HeightInFeet

HeightInInches

HeightInCms

16 a. What is your height?	<input type="text" value="341"/> feet <input type="text" value="342"/> inches OR <input type="text" value="1528"/> m <input type="text" value="975"/> cms
b. What was your weight before you became pregnant? WeightBeforePreg	<input type="text" value="395"/> pounds OR <input type="text" value="976"/> kgs WeightBeforePregInKgs
c. What was your weight at the end of your pregnancy (before delivery)? WeightAtEndOfPreg	<input type="text" value="396"/> pounds OR <input type="text" value="977"/> kgs WeightEndOfPregInKgs

17. How did you feel during your pregnancy compared with other times in your life?

<input checked="" type="radio"/> Much more worried	<input checked="" type="radio"/> Much sadder
<input type="radio"/> More worried 408	<input type="radio"/> Sadder 650
<input type="radio"/> As worried/ calm as other times	<input type="radio"/> As happy/sad as other times
<input type="radio"/> Calmer	<input type="radio"/> Happier
<input type="radio"/> Much calmer FeelingDuringPregnancy	<input type="radio"/> Much happier SadOrHappyFeelingDuringPreg

397 **18. Compared to other children, do you think your child's risk for developing diabetes is: (Mark one)** ChildsRisk_ForDiabetes

Much Lower Somewhat lower About the same Somewhat higher Much higher

407 **19. When you think about your baby's future, do you think:** BabysFuture_DoYouThink

Your child will develop diabetes in the near future

Your child will eventually develop diabetes but a long time from now

Your child will never develop diabetes

You're unsure what will happen

20. When you think about your baby's risk for developing diabetes do you feel

398 <input checked="" type="radio"/> Not at all calm	<input type="radio"/> Somewhat calm	<input type="radio"/> Moderately calm	<input type="radio"/> Very calm	BabysRiskDiabetes_Feel_Calm
399 <input checked="" type="radio"/> Not at all worried	<input type="radio"/> Somewhat worried	<input type="radio"/> Moderately worried	<input type="radio"/> Very worried	BabysRiskDiabetes_Feel_Worried
400 <input checked="" type="radio"/> Not at all relaxed	<input type="radio"/> Somewhat relaxed	<input type="radio"/> Moderately relaxed	<input type="radio"/> Very relaxed	BabysRiskDiabetes_Feel_Relaxed
401 <input checked="" type="radio"/> Not at all tense	<input type="radio"/> Somewhat tense	<input type="radio"/> Moderately tense	<input type="radio"/> Very tense	BabysRiskDiabetes_Feel_Tense
402 <input checked="" type="radio"/> Not at all at-ease	<input type="radio"/> Somewhat at-ease	<input type="radio"/> Moderately at-ease	<input type="radio"/> Very at-ease	BabysRiskDiabetes_Feel_AtEase
403 <input checked="" type="radio"/> Not at all nervous	<input type="radio"/> Somewhat nervous	<input type="radio"/> Moderately nervous	<input type="radio"/> Very nervous	BabysRiskDiabetes_Feel_Nervous

404 **21. Overall, how do you feel about having your baby genetically tested for diabetes risk ?** BabysGeneticTestDiabetesFeeling
 Liked it a lot Liked it a little It was ok Disliked it a little Disliked it a lot

405 **22. Do you think having the baby genetically tested was a good decision ?** BabyGeneticTestGoodDecision
 A great decision A good decision An ok decision A bad decision A very bad decision

406 **23. If a friend was pregnant, would you recommend she have her baby genetically tested for diabetes risk ?**
 No Yes Maybe RecommendGeneticTest_Friends

English Teleform	German Teleform	Swedish Teleform	Finnish Teleform	Spanish Teleform
------------------	-----------------	------------------	------------------	------------------

TEDDY

The Environmental Determinants of Diabetes in the Young

Primary Caretaker Interview

9 Month Clinic Visit

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Valid date range for this visit : **28 Sep 2007** until **27 Dec 2007**.

Interview Date		Visit Location Code	
TEDDY Staff Code			

We would like some information about the TEDDY child's parents and family. Please remember that all answers are confidential.

1. What is your relationship to the TEDDY child? 1692

_Mother _Father _OtherPrimary _Other

Mother
 Father
 Other Primary Caretaker
 Other , specify
RelationshipToChild_

Code (office use only)

2. Who does the TEDDY child live with in this household? (Mark all that apply) 1694

Mother _Mother
 Step-mother _StepMother
 Father _Father ChildLivewithWho_
 Step-father _StepFather
 Brothers or sisters _BrothersOrSisters
 Step-brothers or step-sisters _StepBrothers
 Grandparents _GrandParents
 Other, specify _OthersSpecify

Code (office use only) RelationshipToChildCode

Other	Other Code
<input style="width: 90%;" type="text" value="2155"/>	<input style="width: 90%;" type="text" value="2156"/>
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

ChildLiveWithWhoCode

3. How many children (under the age of 18 years) live in your household? HowManyChildrenHousehold

Please include the TEDDY child in this total:

4. How many adults(18 and older) currently live in your household? HowManyAdultsHousehold

5. How many rooms are in your home? (Do not count bathrooms, porches, halls or balconies) HowManyRoomsHouse

6. Which of the following best describes where you live? 1717

WhereFamilyLives

Rural area
 Small city/village
 Suburb
 Big city

7. What is the marital status of the TEDDY child's parents?

Married
 Unmarried but living together
 Separated ChildParentsStatus
 Divorced
 Unmarried and living apart
 Widowed

8. If the TEDDY child's parents are living apart, think about the parent the child sees less often. How often does this parent see the child?

Parents live together 1908 times per ParentsSeeChildNumTimes
 Day Week Month Year 1893 ChildParentsLiveTogether

9. These next few questions are about the child's mother OR the primary female caretaker living in the household that this form pertains to. (Interviewer: The following questions relate to the mother or primary female caretaker that the child lives with in this household. If the child does not live with the mother or a female caretaker in this household please indicate this and go to question 10).

Does not live with mother or female caretaker 1894

a. What is your (her) first language? Code (office use only) CaretakerFirstLanguage_Code

b. What is your (her) country of birth? Code (office use only) CaretakerBirthCountry_Code

c. Is this your (her) first child? 1702 MomFirstChild No Yes

d. What is your (her) highest grade or level of schooling completed? 1703

Grades 1-9 Grades 10-12
 Graduated High School or awarded a GED Some trade school
 Graduated from trade school Some college or university
 Graduated with a bachelor's degree (for example BA, AB or BS degrees) Some graduate or professional school
 Graduated with a master's degree (for example MA, MS, MBA, MEng, MEd, MSW) Graduated with a doctoral degree (for example MD, DDS, JD, Ph.D., Ed.D degree)
MomHighestGradeComplete

(For Finland) 1966

Grades 1-9 Grades 10-12/high school
 Graduated from high school Some trade school
 Graduated from trade school Some polytechnic/college
 Graduated from polytechnic/college Studied in the university
 University degree Doctor's degree

(For Sweden) 2084

Not finished basic education Finished basic education
 Not finished high school Finished vocationally oriented high school
 Finished other high school Vocational education outside high school
 Not finished college/university Graduated from college or university
 Ongoing graduate studies Finished PhD

e. Does she work outside the home now? 1704 No Yes

If yes, How many hours per week do you (she) work? MomWorkOutsideHome
MomWorkHowManyHoursPerWeek

10. Interviewer: If the child lives with father or a partner in this household please get the following information. (If child does not live with father (partner) in this household please indicate this and go to question 11). **ChildNotLivingWithFather**

Does not live with father or partner 1891

a. What is his (partners) first language? Code (office use only) **Father_FirstLanguage_Code**

b. What is his (partners) country of birth? Code (office use only) **Father_BirthCountry_Code**

c. Is this his (partners) first child? 1710 **FatherFirstChild** No Yes

d. What is his (partners) highest grade or level of schooling completed? 1711

- Grades 1-9
 Grades 10-12
 Graduated High School or awarded a GED
 Some trade school
 Graduated from trade school
 Some college or university
 Graduated with a bachelor's degree (for example BA, AB or BS degrees)
 Some graduate or professional school
 Graduated with a master's degree (for example MA, MS, MBA, MEng, MEd, MSW)
 Graduated with a doctoral degree (for example MD, DDS, JD, Ph.D., Ed.D degree)

FatherHighestLevelSchooling

(For Finland) 1967

- | | |
|--|---|
| <input checked="" type="radio"/> Grades 1-9 | <input type="radio"/> Grades 10-12/high school |
| <input type="radio"/> Graduated from high school | <input type="radio"/> Some trade school |
| <input type="radio"/> Graduated from trade school | <input type="radio"/> Some polytechnic/college |
| <input type="radio"/> Graduated from polytechnic/college | <input type="radio"/> Studied in the university |
| <input type="radio"/> University Degree | <input type="radio"/> Doctor's Degree |

(For Sweden) 2085

- | | |
|---|--|
| <input checked="" type="radio"/> Not finished basic education | <input type="radio"/> Finished basic education |
| <input type="radio"/> Not finished high school | <input type="radio"/> Finished vocationally oriented high school |
| <input type="radio"/> Finished other high school | <input type="radio"/> Vocational education outside high school |
| <input type="radio"/> Not finished college/university | <input type="radio"/> Graduated from college or university |
| <input type="radio"/> Ongoing graduate studies | <input type="radio"/> Finished PhD |

e. Does he (partner) work outside the home now? 1712 **FatherWorkOutsideHome** No Yes

If yes, how many hours per week does he (partner) work? **FatherWorkHowManyHoursPerWeek**

11. What is the biological father's height? feet inches **OR** m cms

Smoke can affect the results of one of our laboratory tests. It will help us to know if the TEDDY child is exposed to smoke of any kind including cigarettes, cigars, or pipes. (Interviewer: Questions 12 and 13 refer to the primary caretakers (asked about in questions 9 and 10) that the child lives with in this household).

12. Do you (mother, female primary caretaker living in this household) currently smoke?* 1911 **MotherFemaleCaretakerSmoke** No Yes Not applicable

If yes, No Yes

a. Do you (mother, female primary caretaker living in this household) smoke in the home? 1719 **MomSmokeInHome** No Yes

b. Do you (mother, female primary caretaker living in this household) smoke in the car? 1720 No Yes

MomSmokeInCar

<p>13. Does the child's father (or other partner <u>living in this household</u>) currently smoke?* If yes, FatherOrPartnerSmoke</p> <p>a. Does he (child's father or other partner <u>living in this household</u>) smoke in the home? DoedHeSmokeInHome</p> <p>b. Does he (child's father or other partner <u>living in this household</u>) smoke in the car? DoedHeSmokeInCar</p>	<p>1912 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not applicable</p> <p>1722 <input type="radio"/> No <input type="radio"/> Yes</p> <p>1723 <input type="radio"/> No <input type="radio"/> Yes</p>																																								
<p>14. Does the child regularly spend time with anyone else who smokes?* ChildSpendTimeWithSmoker</p>	<p>1724 <input type="radio"/> No <input type="radio"/> Yes</p>																																								
<p>15. Are there any animals or pets in the TEDDY child's house (<u>the household that this form pertains to</u>)? If yes, please tell us what kind of pet and how many:</p> <table border="1" data-bbox="37 283 519 598"> <tr> <td>Cat</td><td><input type="text" value="1896"/></td> <td>Snake</td><td><input type="text" value="1901"/></td> </tr> <tr> <td>Dog</td><td><input type="text" value="1895"/></td> <td>Rabbit</td><td><input type="text" value="1902"/></td> </tr> <tr> <td>Bird</td><td><input type="text" value="1897"/></td> <td>Fish</td><td><input type="text" value="1903"/></td> </tr> <tr> <td>Guinea Pig</td><td><input type="text" value="1898"/></td> <td>Turtle</td><td><input type="text" value="1904"/></td> </tr> <tr> <td>Hamster</td><td><input type="text" value="1899"/></td> <td>Rat</td><td><input type="text" value="1905"/></td> </tr> <tr> <td>Mouse</td><td><input type="text" value="1900"/></td> <td>Lizard</td><td><input type="text" value="1906"/></td> </tr> <tr> <td>Other</td><td><input type="text" value="1907"/></td> <td>Code (office use only)</td><td><input type="text" value="1727"/></td> </tr> <tr> <td colspan="4">Other Code</td> </tr> <tr> <td><input type="text" value="2140"/></td><td><input type="text" value="2141"/></td><td colspan="2"></td> </tr> <tr> <td colspan="4"><input type="button" value="Add"/></td> </tr> </table> <p>AreThereAnyPets_</p> <p>AreThereAnyPets_OtherWhat</p>	Cat	<input type="text" value="1896"/>	Snake	<input type="text" value="1901"/>	Dog	<input type="text" value="1895"/>	Rabbit	<input type="text" value="1902"/>	Bird	<input type="text" value="1897"/>	Fish	<input type="text" value="1903"/>	Guinea Pig	<input type="text" value="1898"/>	Turtle	<input type="text" value="1904"/>	Hamster	<input type="text" value="1899"/>	Rat	<input type="text" value="1905"/>	Mouse	<input type="text" value="1900"/>	Lizard	<input type="text" value="1906"/>	Other	<input type="text" value="1907"/>	Code (office use only)	<input type="text" value="1727"/>	Other Code				<input type="text" value="2140"/>	<input type="text" value="2141"/>			<input type="button" value="Add"/>				<p>1725 <input type="radio"/> No <input type="radio"/> Yes</p>
Cat	<input type="text" value="1896"/>	Snake	<input type="text" value="1901"/>																																						
Dog	<input type="text" value="1895"/>	Rabbit	<input type="text" value="1902"/>																																						
Bird	<input type="text" value="1897"/>	Fish	<input type="text" value="1903"/>																																						
Guinea Pig	<input type="text" value="1898"/>	Turtle	<input type="text" value="1904"/>																																						
Hamster	<input type="text" value="1899"/>	Rat	<input type="text" value="1905"/>																																						
Mouse	<input type="text" value="1900"/>	Lizard	<input type="text" value="1906"/>																																						
Other	<input type="text" value="1907"/>	Code (office use only)	<input type="text" value="1727"/>																																						
Other Code																																									
<input type="text" value="2140"/>	<input type="text" value="2141"/>																																								
<input type="button" value="Add"/>																																									
<p>16. Does the TEDDY child live on a farm with animals, or are there animals that live outside the house (<u>the household that this form pertains to</u>)?</p> <p><input type="checkbox"/> Cat <input type="checkbox"/> Goat</p> <p><input type="checkbox"/> Dog <input type="checkbox"/> Chicken 1729</p> <p><input type="checkbox"/> Cow <input type="checkbox"/> Horse</p> <p><input type="checkbox"/> Pig <input type="checkbox"/> Goose</p> <p><input type="checkbox"/> Duck <input type="checkbox"/> Other, what?</p> <p><input type="checkbox"/> Sheep</p> <p>Code (office use only) <input type="text" value="1730"/></p> <p>Other codes</p> <p><input type="text" value="3714"/></p> <p><input type="button" value="Add"/></p> <p>TypeAnimalsAtFarm_</p> <p>ChildLiveOnFarmWithAnimals</p>	<p>1728 <input type="radio"/> No <input type="radio"/> Yes</p>																																								

TEDDY

Print Teleform

The Environmental Determinants of Diabetes in the Young**Participant in Non-TEDDY Research Form**

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	
Date form completed:	<input type="text"/>	Event_age	<input type="text"/>
	<input type="text"/>	Visit Location Code	<input type="text"/>
TEDDY Staff Code	<input type="text"/>		

TEDDY Subject Participation in Other Human Research

Ask subject to bring a copy of the informed consent document to the TEDDY visit (if he/she still has it).
Obtain the answers for questions 1-5 from the parent or primary caretaker.

1. Title of Research study

2250 Title1

2729 Title2

2730 Title3

2. Institution

2251 Institution1

2731 Institution2

No change since last submittal of form 3987 Nochangeinstitutionsincelast

3. Study contact person

2252 Last Name

2253 First Name

No change since last submittal of form 3988 Nochangeinstudycontactpersonfi

4. Phone number for study contact

2254

No change since last submittal of form 3989

5. Date of last study visit (approximate date is acceptable)

2255 2256 2257

Study participation is ongoing 2258 Study participation has ended StudyParticipationStatus

No change since last submittal of form 3990 Nochangeindateoflaststudyvisit

Obtain the answers for questions 6-10 from a staff member from the other study that the TEDDY subject is enrolled in.

6. Number of study visits per year

2249

AttendsStudyVisitsOnAnAsNeeded

Attends study visits on an as needed basis No change since last submittal of form 3519 3991 Nochangeinnumberofstudyvisitsp

NumOfStudyVisitsPerYear

7. Has the child provided one or more blood samples for this study?

Yes No 2241 HasChildProvidedBloodSamples

No change since last submittal of form 3992 Nochangeaboutbloodsamples

8. What other (if any) biological samples have been obtained for this study (e.g. urine, saliva, biopsy)?

2242 Code 2245 BiologicalSamplesCode1

OtherBiologicalSamplesObtained Code 2246 BiologicalSamplesCode2

No change since last submittal of form 3993 Nochangeaboutbiologicalsamples

9. Has the child received any medication as part of being in this study?

Yes No 2243 ChildReceivedAnyMedication

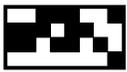
No change since last submittal of form 3994 Nochangeinmedicationsreceiveda

10. If you answered yes to Question 9, do you know what the medication is?

2244 Medication Code 2247 MedicationCode1

Code 2248 MedicationCode2

No change since last submittal of form 3995 Nochangeaboutmedicationssincel



60634

Local Use Only

SubjectID

Participant in Non-TEDDY Research Form

Office Use Only

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Date form completed:

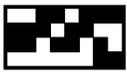
EVENT_AGE

(DD/MMM/YYYY - Example 01/JAN/2004)

Person Completing Form: _____

TEDDY Staff Code:

If a TEDDY subject is currently participating or has participated in another research study, besides TEDDY, please use this form to collect information about the study. This form should be completed by the TEDDY staff member. If study participation is ongoing, the form should be filled out at each subsequent visit until the subject's participation has ended. When a subject indicates that participation in the other study has ended, no further documentation is required. Obtain the answers for questions 1-5 from the parent or primary caretaker; obtain the answers for questions 6-14 from a staff member from the other study that the TEDDY subject is enrolled in.



60634

Local Use Only

SubjectID

Obtain the answers for questions 6-14 from a staff member from the other study that the TEDDY subject is enrolled in.

6. Number of study visits per year:

Attends study visits on an as needed basis

ATTENDSSTUDYVISITSONANASNEEDED

No change since last submittal of form

NOCHANGEINNUMBEROFSTUDYVISITSP

7. Has the child provided one or more blood samples for this study?

HASCHILDPROVIDEDBLOODSAMPLES

Yes No

No change since last submittal of form

NOCHANGEABOUTBLOODSAMPLES

8. What other (if any) biological samples have been obtained for this study (e.g. urine, saliva, biopsy)?

OTHERBIOLOGICALSAMPLESOBTAINED

_____ **BIOLOGICALSAMPLESCODE1**

Code (office use only)

_____ **BIOLOGICALSAMPLESCODE2**

Code (office use only)

No change since last submittal of form

NOCHANGEABOUTBIOLOGICALSAMPLES

9. Has the child received any medication as part of being in this study?

CHILDRECEIVEDANYMEDICATION

Yes No

No change since last submittal of form

NOCHANGEABOUTMEDICATIONSSINCEL

10. If you answered yes to Question 9, do you know what the medication is?

_____ **MEDICATION** **MEDICATIONCODE1**

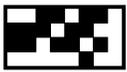
Code (office use only)

_____ **MEDICATION** **MEDICATIONCODE2**

Code (office use only)

No change since last submittal of form

NOCHANGEINMEDICATIONSRECEIVEDA



60634

Local Use Only

SubjectID

11. Has the child received any vaccine as part of being in this study? **CHILDRECEIVEDANYVACCINE**

Yes No

No change since last submittal of form **NOCHANGEINTHEVACCINATIONSRECEI**

12. If you answered yes to Question 11, do you know what the vaccine is? **YESTOQUESTION11**

VACCINATIONCODE1

Code (office
use only)

VACCINATIONCODE2

Code (office
use only)

No change since last submittal of form **NOCHANGEABOUTVACCINATIONSSINCE**

13. Has the child received any dietary supplement as part of being in the study? **HASTHECHILDRECEIVEDANYDIETARYS**

Yes No

No change since last submittal of form **NOCHANGEABOUTDIETARYSUPPSINCEL**

14. If you answered yes to Question 13, do you know what the dietary supplement is? **YESTOQUESTION13**

DIETARYSUPPLEMENTCODE1

Code (office
use only)

DIETARYSUPPLEMENTCODE2

Code (office
use only)

No change since last submittal of form **NOCHANGEINDIETARYSUPPLEMENTREC**

TEDDY

The Environmental Determinants of Diabetes in the Young

Save Form

Print Form

Close/Refresh Form

Eleven Year Six Month OGTT Sample Collection Form

This form can only be used for samples collected between **02 Jun 2016** and **01 Dec 2016**

Subject ID	Local Code	Clinical Center	Visit Location Code	Date of Collection		
				<input type="checkbox"/> Sample Processed according to standard protocol or Standard protocol followed, Insufficient Volume		
						Today

Use with Long-Distance Protocol Only	
<input type="checkbox"/> Long-Distance Protocol Insufficient Volume	
Date sample was processed:	Time sample was processed (this is the time the sample was put in the freezer): * Record time in Universal Time - Eg., 2:00 pm would be recorded as 14:00

TOTAL_GLUKOSE

Total dose of glucose: g (1.75 g per Kg of body weight)

Time	Blood Glucose Levels	Type of Sample	Time sample was drawn Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00	Time sample was processed (this is the time the sample was placed in the freezer) Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00
ELAPSED_MINUTES -10 minutes Insulin		<input type="radio"/> SAMPLE_TYPE_CD Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/> TIME_DRAWN	TIME_PROCESSED <input type="text"/>
-10 minutes Glucose		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
-10 minutes C-peptide		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>

0 minutes Insulin		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
0 minutes Glucose	Lab Blood Glucose Level: <input type="text"/> mg/dL (or) BLOOD_GLUCOSE_MGDL <input type="text"/> mmol/L BLOOD_GLUCOSE_MMOL	<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma <input type="radio"/> Capillary Blood	<input type="text"/>	<input type="text"/>
0 minutes C-peptide		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
30 minutes Insulin		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
30 minutes Glucose		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
30 minutes C-peptide		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
60 minutes Insulin		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
60 minutes Glucose		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
60 minutes C-peptide		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
90 minutes Insulin		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
90 minutes Glucose		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
90 minutes C-peptide		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
120 minutes Insulin		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>
120 minutes Glucose	Lab Blood Glucose Level: <input type="text"/> mg/dL (or) BLOOD_GLUCOSE_MGDL <input type="text"/> mmol/L BLOOD_GLUCOSE_MMOL	<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma <input type="radio"/> Capillary Blood	<input type="text"/>	<input type="text"/>
120 minutes C-peptide		<input type="radio"/> Venous Blood <input type="radio"/> Venous Plasma	<input type="text"/>	<input type="text"/>

<input type="checkbox"/> Autofill Insufficient Volume/Not Collected					
Test Name	Vial Barcode Number	Sample Volume	Box Number	Space Number	Insufficient Volume
-10 minutes Insulin	<input type="text"/> (Green Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

-10 minutes Glucose	<input type="text"/> (Gray Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
-10 minutes C-peptide	<input type="text"/> (Purple Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
0 minutes Insulin	<input type="text"/> (Green Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
0 minutes Glucose	<input type="text"/> (Gray Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
0 minutes C-peptide	<input type="text"/> (Purple Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
30 minutes Insulin	<input type="text"/> (Green Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
30 minutes Glucose	<input type="text"/> (Gray Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
30 minutes C-peptide	<input type="text"/> (Purple Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
60 minutes Insulin	<input type="text"/> (Green Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

60 minutes Glucose	<input type="text"/> (Gray Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
60 minutes C-peptide	<input type="text"/> (Purple Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
90 minutes Insulin	<input type="text"/> (Green Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
90 minutes Glucose	<input type="text"/> (Gray Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
90 minutes C-peptide	<input type="text"/> (Purple Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
120 minutes Insulin	<input type="text"/> (Green Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
120 minutes Glucose	<input type="text"/> (Gray Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
120 minutes C-peptide	<input type="text"/> (Purple Cap Insert)	<input type="text"/> mL	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Instructions

1. See TEDDY MOO section 13 for instructions on completing an OGTT.
2. Choose the visit location code from the drop down menu and enter the Date of Draw (DD/MMM/YYYY) on this form.
3. Enter the total dose of glucose in grams in the corresponding field.
4. For the -10 minutes Insulin sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
5. For the -10 minutes Glucose sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
6. For the -10 minutes C-peptide sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
7. For the 0 minutes Insulin sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer).
8. For the 0 minutes Glucose sample, enter the blood glucose level (in mg/dL or mmol/L; note the Swedish sites should enter a blood glucose level in both the Hemocue1 field and Hemocue2 field), indicate the type of sample (venous blood, capillary blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer).
9. For the 0 minutes C-peptide sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer).
10. For the 30 minutes Insulin sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
11. For the 30 minutes Glucose sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
12. For the 30 minutes C-peptide sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
13. For the 60 minutes Insulin sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
14. For the 60 minutes Glucose sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
15. For the 60 minutes C-peptide sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.
16. For the 90 minutes Insulin sample, indicate the type of sample (venous blood or venous plasma) and

freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.

17. For the 90 minutes Glucose sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.

18. For the 90 minutes C-peptide sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer). If the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, leave these data fields blank.

19. For the 120 minutes Insulin sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer).

20. For the 120 minutes Glucose sample, enter the blood glucose level (in mg/dL or mmol/L note the Swedish sites should enter a blood glucose level in both the Hemocue1 field and Hemocue2 field), indicate the type of sample (venous blood, capillary blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer).

21. For the 120 minutes C-peptide sample, indicate the type of sample (venous blood or venous plasma) and enter the time the sample was drawn and the time the sample was processed (the time sample is placed in freezer).

22. Find the row containing the "Test Name" (i.e. -10 minutes Insulin, -10 minutes Glucose, -10 minutes C-peptide, 0 minutes Insulin, 0 minutes Glucose, 0 minutes C-peptide, etc) of the sample in the vial you would like to scan. If an insufficient blood volume amount was obtained, and there is not enough blood for that particular Test Name or if the subject refused the six time-point OGTT and a two time-point OGTT was completed instead, check the "Insufficient Blood Volume" Box in that row, repeat this step as necessary then continue to step 29; if there is a sufficient amount of blood go to step 23.

23. Place cursor in the "Vial Barcode Number" box in this row.

24. Scan the preprinted barcode located on the cryovial containing this particular sample.

25. In the provided space, enter the sample volume (mL) contained in the cryovial.

26. In the provided space enter box number and space number where the sample will be stored.

27. Place the cryovial in the exact freezer box and space number that you entered on the SCF for that particular sample. The lab has requested that sites place all of the subject's Insulin, Glucose and C-peptide samples collected at one visit right next to each other in the freezer box so that the samples can be analyzed together at the lab.

28. Repeat steps 22-27 as necessary.

29. When all information for this specific SCF has been entered, click the "Save Form" button at the top of this form

30. Store the samples at -70°C. If a six time-point OGTT was completed the Insulin, Glucose and C-peptide samples from all six time-points should be shipped to the MMTT/OGTT lab for analysis. If a two time-point OGTT was completed the remaining blood from the 0 minute glucose sample should be shipped to the MMTT/OGTT lab for analysis and if a 120 minute venous glucose sample is available the remaining blood from this sample should also be shipped to the lab for analysis; the insulin and C-peptide samples collected at time 0 minutes and 120 minutes (if venous blood is available) should be shipped to the MMTT/OGTT lab for analysis. The lab has requested that sites place all of the subject's Insulin, Glucose and C-peptide samples collected at one visit right next to each other in the freezer box so that the samples can be analyzed together at the lab. Send samples to the lab in bulk shipments on dry ice once a month.

Form Revision Date: 1 July 2016

TEDDY Parent Experience Survey

* These fields are required in order to SAVE the form.
 * These additional fields are required in order to make the form complete.

Subject ID	MASKID	Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	
Date Form was Reviewed	<input type="text" value="3526"/> <input type="text" value="3527"/> <input type="text" value="3528"/> *	Visit Location Code	<input type="text" value=""/> *
TEDDY Staff Code	<input type="text" value=""/> *		
Subject on Long Distace Protocol? 3567			
<input checked="" type="radio"/> Yes <input type="radio"/> No LONGDISTANCEPROTOCOL			

Thank you for your continued participation in the TEDDY Study. We want to learn more about your decision to join and stay in TEDDY. We would like to learn what is working well for you and ways that we can improve your TEDDY experience. We want your honest answers. Your answers will be kept private. Your name or your child's name will not be used. We will use your answers to do a better job of making the TEDDY experience a good one for our study families. Thanks for your help!

1. Date you completed this questionnaire: * EVENT_AGE

2. What is your relationship to the TEDDY child? Mark all that apply. 3529

Mother RELATIONSHIPTOTEDDYC_MOTHER
 Father RELATIONSHIPTOTEDDYC_FATHER
 Other Primary Caretaker RELATIONSHIPTOTEDDYC_OTHERPRIMAR
 Other RELATIONSHIPTOTEDDYC_OTHER
 Mother + Father completed form together RELATIONSHIPTOTEDDYC_MOTHERFATHE

Code OTHERRELATIONSHIPCODE RELATIONSHIPTOTEDDYC_OTHER

3. Listed below are some of the reasons that people stay in TEDDY. We would like to know how important each of these reasons is to you. Fill in the circle that is right for you.

	Reasons for staying in TEDDY?	How important is this reason to you?
3530	Knowing someone is watching my child for the development of diabetes WATCHINGCHILDFORDEVELOFDIABETE	<input checked="" type="radio"/> Very Important <input type="radio"/> Important <input type="radio"/> Not So Important
3531	Getting my child's antibody results GETTINGCHILDANTIBODYRESULTS	<input checked="" type="radio"/> Very Important <input type="radio"/> Important <input type="radio"/> Not So Important
3532	Keeping the TEDDY Book KEEPINGTHETEDDYBOOK	<input checked="" type="radio"/> Very Important <input type="radio"/> Important <input type="radio"/> Not So Important
3533	Knowing my child might be able to participate in future prevention studies CHILDPARTICIPATEFUTURESTUDIES HELPSCIENCEISCOVERYTYPE1DIAB	<input checked="" type="radio"/> Very Important <input type="radio"/> Important <input type="radio"/> Not So Important
3534	Helping science discover the causes of type 1 diabetes HELPSCIENCEISCOVERYTYPE1DIAB	<input checked="" type="radio"/> Very Important <input type="radio"/> Important <input type="radio"/> Not So Important
3535	Being seen by the same TEDDY nurse/staff at each visit SEENBYSAMETEDDYSTAFF	<input checked="" type="radio"/> Very Important <input type="radio"/> Important <input type="radio"/> Not So Important
	Other, Please tell us: OTHERPLEASETELLUSCODE1 OTHERPLEASETELLUSCODE2	Code <input type="text" value="3536"/> Code <input type="text" value="3537"/>

The TEDDY Study Clinics around the world do many different things for participants to make their TEDDY experience a good one. We would like to know what you think of these efforts and also get your opinion about other things we are thinking about trying.

4. Please tell us whether you like this particular part of TEDDY and which of these efforts you would recommend that we continue. Please fill in the circle that is right for you for each item below.

(For Colorado, Washington and Georgia/Florida)	
	Did you like that the TEDDY clinic did this?
Gifts at TEDDY Visits <small>GIFTSFORCHILDREN</small>	
3540	Gifts for children (Teddy Bear, snack/sippy cups, Willie Goes To TEDDY, etc) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3541	Gifts for parents (water bottles, sunscreen, lotion, etc) <small>GIFTSFORPARENTS</small> <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event (For Colorado and Washington)
3542	Toy Chest for children <small>TOYCHESTFORCHILDREN</small> <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
Payments, Coupons, Cards / Reimbursements	
3543	Payments/ Reimbursements for visits <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3544	Payments/Reimbursements for stool samples <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3545	Gift Cards (For Colorado + Georgia/Florida) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3581	Valet and/or free parking (For Georgia/Florida) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3582	Mileage Compensation (For Georgia/Florida) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3583	Bonuses for consistent stool samples (For Georgia/Florida) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
Connecting with Families	
3546	Meeting with TEDDY doctors (For Colorado and Washington) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3715	Meeting with TEDDY staff (For Georgia/Florida) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3547	Newsletter with TEDDY Updates <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3548	Holiday Cards <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3549	Local TEDDY Website (For Colorado) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3550	International TEDDY Website <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3551	Activities for Parents/Families <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event

3543. PAYMENTREIMBURSEMENTFORVISITS

3544. PAYMENTSFORSTOOLSAMPLES

3545. GIFTCARDS

3581. VALETANDORFREEPARKINGGEO

3582. MILEAGECOMPENSATIONGEO

3583. BONUSCONSISTSTOOLSAMPLEGEO

3546. MEETINGWITHTEDDYDOCTORS

3715. MEETINGWITHTEDDYSTAFFGEO

3547. NEWSLETTERWITHTEDDYUPDATES

3548. HOLIDAYCARDS

3549. LOCALTEDDYWEBSITE

3550. INTERNATIONALTEDDYWEBSITE

3551. ACTIVITIESFORPARENTSFAMILIES

5. We are always looking for ways to make your TEDDY experience a good one. We would like your feedback on the ideas listed below.

(For Colorado, Washington and Georgia/Florida)

3552

a. Would you be interested in participating in parents focus groups?
 Yes No **INTERESTPARENTFOCUSGROUP**

3553

b. Would you be interested in attending a TEDDY party in the future?
 Yes No **INTERESTTEDDYPARTYINFUTURE**

3554

c. How would you like to receive the TEDDY newsletter?
 Mail Email **RECEIVENEWSLETTERS_BYEMAIL RECEIVENEWSLETTERS_BYMAIL**

3555

d. Do you think it is a good idea to give some of the clinic visit payment/ reimbursement to your TEDDY child? **GIVECLINICVISITPAYMENTTOCHILD**
(For Colorado and Washington)

3584

Yes No
(For Georgia/Florida)
 Yes No Already doing this **CLINICVISITPAYMENTTOCHILDEFL**
(For Colorado, Washington and Georgia/Florida)

If Yes:

At what age do you think would be a good time to give your TEDDY child a cash payment of \$10-\$25 for completing the clinic visit? **AGETOGIVECHILDCASHFORVISIT**

Age of the TEDDY child

6. Below is a list of different parts of participating in TEDDY. Please tell us how these parts are working for you by filling in the circle that best describes your experience.

3557	REMINDESFORTHETEDDYVISITS Reminders for the TEDDY visits	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3558	WORKINGWITHTHETEDDYSTAFF Working with the TEDDY staff	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3559	GETTINGMYQUESTIONSANSWERED Getting my questions answered	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3560	DAYTIMEVISITSCHEDULED Day or time TEDDY visits are scheduled	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3561	WAITBEFORETHETEDDYVISITSTARTS How long you wait before the TEDDY visit starts	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3562	CLINICSETTINGORENVIRONMENT Clinic setting or environment	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3563	TIMETOCOMPLETEVISIT The time it takes to complete a TEDDY visit	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3564	TRANSPORTTOTEDDYVISIT Transportation to the TEDDY visit	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3565	PARKINGFORATEDDYVISIT Parking for a TEDDY visit	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3566	MAILINGPOOPSAMPLECENTER Mailing poop sample to the TEDDY Center	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement
3680	(For Germany) Mailing blood samples to the TEDDY Center	<input checked="" type="radio"/> Works Great/ Not a problem	<input type="radio"/> Works Good Most of the Time-Sometimes a problem	<input type="radio"/> Needs Improvement

MAILINGBLOODSAMPLECENTERGER

7. What else can we do to make TEDDY a better experience for you and your family?			
	<small>TEDDYBETTEREXPERIENCECODE1</small>	<small>TEDDYBETTEREXPERIENCECODE2</small>	<small>TEDDYBETTEREXPERIENCECODE3</small>
Codes	<input type="text" value="3522"/>	<input type="text" value="3523"/>	<input type="text" value="3524"/>
8. Have you ever thought about leaving TEDDY? 3525			
	<small>THOUGHTABOUTLEAVINGTEDDY</small>		
<input checked="" type="radio"/> Yes	<input type="radio"/> No	<small>LEAVINGTEDDYCODE1</small>	<small>LEAVINGTEDDYCODE2</small>
Codes	<input type="text" value="3569"/>	<input type="text" value="3570"/>	<input type="text" value="3571"/>

The TEDDY Study Clinics around the world do many different things for participants to make their TEDDY experience a good one. We would like to know what you think of these efforts and also get your opinion about other things we are thinking about trying.

4. Tell us what you think of the issues related to the TEDDY study listed below. Even if your child did not, for example, have any need to see a physician during office hours, tell us whether you consider such an opportunity necessary. Circle the number corresponding to your opinion.

(For Finland)	
	Issues related to the TEDDY study?
3716	Opportunity to see the doctor during office hours when necessary SEEDOCTORDURINGOFFICEHOURFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3717	Opportunity to call the doctor when necessary CALLDOCTORWHENNECESSARYFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3718	Opportunity to call my study nurse when necessary CALLSTUDYNURSENECESSARYFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3719	Small gifts received during the study visit (e.g., Teddy bear, bunny, rabbit, mittens, beach ball) SMALLGIFTSRECEIVEDVISITFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3720	TEDDY newsletters TEDDYNEWSLETTERSFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3721	Christmas card CHRISTMASCARDFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3722	Christmas calendar CHRISTMASCALENDARFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3723	TEDDY home pages TEDDYHOMEPAGESFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received
3724	International TEDDY home pages INTERTEDDYHOMEPAGESFIN <input checked="" type="radio"/> I like/would like it a lot <input type="radio"/> The issue is not significant to me <input type="radio"/> I don't/ wouldn't like it <input type="radio"/> I have not needed/received

5. Below are some issues and plans on which we would like to hear your opinions. Please check the alternative or alternatives corresponding to your opinion.

(For Finland)

5.1 If you had been given the opportunity to have examinations and treatment for each of your child's illnesses done during business hours by the TEDDY study doctor, would you have used this service? BUSINESSHOURSUSEDVISITFIN

3725

- I would always have used
- I would have used now and then
- I would probably not have used at all

5.2 What do you think of the waiting area of the study?

3726

- I wish the waiting area were larger THINKOFWAITINGAREAFI_IWISHTHEWA1
- I wish the waiting area had the following kinds of toys for children THINKOFWAITINGAREAFI_IWISHTHEWA2
- I wish the waiting area had more hobby and reading magazines and books for children THINKOFWAITINGAREAFI_IWISHTHEWA3
- I wish the waiting area had more reading matter for adults THINKOFWAITINGAREAFI_IWISHTHEWA4
- I wish the waiting area were neater THINKOFWAITINGAREAFI_IWISHTHEWA5
- I wish the waiting area had THINKOFWAITINGAREAFI_IWISHTHEWA6
- I think the waiting area works well as it is THINKOFWAITINGAREAFI_IWISHTHEWA

I wish the Waiting area had the following kinds of toys for children

WAITINGAREATOYS CODE1FIN WAITINGAREATOYS CODE2FIN
Code 1 Code 2

WAITINGAREAHAD CODE1FIN
I wish the waiting area had WAITINGAREAHAD CODE2FIN
Code 1 Code 2

5.3 Do you usually have to wait before you are admitted for laboratory tests? WAITBEFOREADMITINLABFIN

3729

- We don't usually have to wait
- Now and then we have to wait
- We almost always have to wait an average of

AVERAGEWAITINMINUTESFIN
minutes

Communication about the study is considered important in the TEDDY study. There is a desire to develop it in a way we would like. Please check the alternative or alternatives corresponding to your opinion.

5.4 How would you like to receive newsletters on the TEDDY study? TORECEIVETEDDYNEWSLETTER

3731

- By e-mail RECEIVENEWSLETTERONS_BYEMAIL
- From the TEDDY study home pages by Internet RECEIVENEWSLETTERONS_FROMTHETEDD
- By mail RECEIVENEWSLETTERONS_BYMAIL
- I am not interested in TEDDY newsletters RECEIVENEWSLETTERONS_IAMNOTINTER

5.5. Currently participating in the TEDDY study are a total of more than 1200 children in Turku, Tampere and Oulu. If an evening event were to be organized for the participating families, where results of the study and what studies are being planned would be reported, would you attend this event in your city?

3732

- I would very likely attend EVENINGEVENTATTENDEFI_IWOULDVERYL
- I might possibly attend EVENINGEVENTATTENDEFI_IMIGHTPOSSI
- I would not attend EVENINGEVENTATTENDEFI_IWOULDNOTAT
- I'd like to attend, but for practical reasons I don't believe I could attend an evening event EVENINGEVENTATTENDEFI_IDLIKETOATT
- I support a smaller event to which only about 50 families at a time would be invited EVENINGEVENTATTENDEFI_ISUPPORTASM

5.6. In what other ways could we improve communications?

3733

- I would like the study doctor regularly to tell us about new research results related to diabetes, e.g. once a year WAYSTOCOMMUNICATEFIN_IWOULDLIKE1
- I would like more information in connection with appointments with the study nurse WAYSTOCOMMUNICATEFIN_IWOULDLIKEM
- I would like to get more information concerning the laboratory tests at study visits WAYSTOCOMMUNICATEFIN_IWOULDLIKE2
- I would like WAYSTOCOMMUNICATEFIN_IWOULDLIKE
- Current communications are sufficient for me WAYSTOCOMMUNICATEFIN_CURRENTCOMM

I would like (code)

Code 1 IWOULDLIKECODE1FIN
Code 2 IWOULDLIKECODE2FIN

The TEDDY Study Clinics around the world do many different things for participants to make their TEDDY experience a good one. We would like to know what you think of these efforts and also get your opinion about other things we are thinking about trying.

4. Please tell us whether you like this particular part of TEDDY and which of these efforts you would recommend that we continue. Please fill in the circle that is right for you for each item below.

(For Sweden)	
	Did you like that the TEDDY clinic did this?
3688	<p style="text-align: center; color: red; font-size: small;">MOREEXPENSIVEGIFTSFORTHECHILDR</p> More "expensive" gifts for the children <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3689	<p style="text-align: center; color: red; font-size: small;">SMALLGIFTSFORTHECHILDRENSWE</p> Small gifts for the children (tatoos etc) <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3690	<p style="text-align: center; color: red; font-size: small;">CHRISTMASCARDSWE</p> Christmas Card <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3691	<p style="text-align: center; color: red; font-size: small;">INFOLETTERABOUTHAPPENINGINTEDE</p> Information letters about what is happening in TEDDY <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3692	<p style="text-align: center; color: red; font-size: small;">PARENTMEETINGTEDDYSWE</p> Recurring parent meetings about TEDDY <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3693	<p style="text-align: center; color: red; font-size: small;">TEDDYLOCALHOMEPAGESWE</p> TEDDY's local home page <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3694	<p style="text-align: center; color: red; font-size: small;">TEDDYINTERNATIONALHOMEPAGESWE</p> TEDDY's international home page <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3695	<p style="text-align: center; color: red; font-size: small;">REIMBURSEMENTFORTRAVELSW</p> Reimbursement for travel <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event
3696	<p style="text-align: center; color: red; font-size: small;">TEDDYPARKINGSWE</p> TEDDY parking <input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event

5. We know it is sometimes difficult to remember the TEDDY visits. Would you like a reminder when it is time to come to the TEDDY clinic? LIKETOBEREMINDEDSWE

(For Sweden)

3697

Would you like a reminder when it is time to come to the TEDDY clinic?
REMINDERTOCOMETEDDYCLINICSWE

Yes No

3698

How would you like to be reminded?
LIKETOBEREMINDEDSWE

email
 mail
 telephone
 sms

The TEDDY Study Clinics around the world do many different things for participants to make their TEDDY experience a good one. We would like to know what you think of these efforts and also get your opinion about other things we are thinking about trying.

4. Please tell us whether you like this particular part of TEDDY and which of these efforts you would recommend that we continue. Please fill in the circle that is right for you for each item below.

(For Germany)	
<p>Gifts (HIPP- package, towel...)Which gift did you like the most? GIFTSHIPPACKAGE/TOWELGER GIFTYOULIKETHEMOSTGER</p> <p>3681</p> <p>Code 3668</p> <p>Do you have any ideas for new presents? HAVEANYIDEASNEWPRESENTSGER</p> <p>3682</p> <p>Code 3669</p> <p>Code 3670</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p> <p style="text-align: right;">3667</p> <p>CODEFORTHEGIFTYOULIKETHEMOSTGE</p> <p>CODE1FORANYIDEASFORNEWPRESENTS</p> <p>CODE2FORANYIDEASFORNEWPRESENTS</p>
<p>Payments</p> <p>for visits PAYMENTSFORVISITSGER 3683</p> <p>for digital scale PAYMENTSFORDIGITALSCALEGER 3671</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p> <p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
Communication	
<p>Telephone calls with the TEDDY staff TELECALLSWITHTEDDYSTAFFGER 3672</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>Personal meeting with the TEDDY staff PERSMEEETWITHTEDDYSTAFFGER 3673</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>Meeting with TEDDY doctors MEETNGWITHTEDDYDOCTORSGER 3684</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>Newsletter NEWSLETTERGER 3685</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>Christmas and birthday cards CHRISMASBIRTHCARDSGER 3674</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>Painting contest PAINTINGCONTESTGER 3675</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>International TEDDY website INTERNATIONALTEDDYWEBSITEGER 3686</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
Planned activities	
<p>Local TEDDY website LOCALTEDDYWEBSITEGER 3687</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>
<p>TEDDY summer party in Munich TEDDYSUMMERPARTYMUNICHGER 3676</p>	<p><input checked="" type="radio"/> Liked it a lot <input type="radio"/> Neutral <input type="radio"/> Didn't like it <input type="radio"/> N/A Didn't receive item or go to event</p>

5. We are always looking for ways to make your TEDDY experience a good one. We are always endeavored to match your interests. Please tell us again when and how we can reach you the best.

(For Germany)

3677	How would you like to be reminded of the next stool sample/ the next visit? <i>REMINDEDNEXTSTOOLSAMPLEVISITGE</i>	<input checked="" type="radio"/> Per mailing <input type="radio"/> Per telephone <input type="radio"/> Per Email <input type="radio"/> I don't need reminders
3678	Which weekday is best for you to be reached via telephone?	<input checked="" type="radio"/> Monday <input type="radio"/> Tuesday <input type="radio"/> Wednesday <input type="radio"/> Thursday <input type="radio"/> Friday <input type="radio"/> Anytime
3679	Which time of the day is best for you to be reached via telephone? <i>TIMEOFDAYTOREACHVIATELEGER</i>	<input checked="" type="radio"/> 8:00-10:00 <input type="radio"/> 10:00-12:00 <input type="radio"/> 12:00-14:00 <input type="radio"/> 14:00-16.00 <input type="radio"/> 16:00-18:00 <input type="radio"/> Anytime

PedsQL™
Diabetes Module
Version 3.2

PARENT REPORT for CHILDREN (ages 8-12)

DIRECTIONS

Children with diabetes sometimes have special problems. On the following page is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** during the **past ONE month** by selecting:

- 0** if it is **never** a problem
- 1** if it is **almost never** a problem
- 2** if it is **sometimes** a problem
- 3** if it is **often** a problem
- 4** if it is **almost always** a problem

There are no right or wrong answers.
If you do not understand a question, please ask for help.



SubjectID

Date you completed this questionnaire:

 / /

DATECOMPLETEDQUESTIONNAIREAGE

(DD/MMM/YYYY - Example 01/JAN/2004)

What is your relationship to the child? RELATIONSHIPTOCHILD_

- Mother MOTHER
 Father FATHER
 Other Primary Caretaker OTHERPRIMARY
 Other, specify OTHER

Code (office use only)

RELATIONSHIPTOCHILDCODE

In the past **ONE month**, how much of a **problem** has your child had with ...

DIABETES (problems with...)	Never	Almost Never	Some-Times	Often	Almost Always
1. Feeling hungry	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>FEELINGHUNGRY</small>
2. Feeling thirsty	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>FEELINGTHIRSTY</small>
3. Having to go to the bathroom too often	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>HAVINGTOGOBATHROOMTOOOFTEN</small>
4. Having tummy aches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>HAVINGTUMMYACHES</small>
5. Having headaches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>HAVINGHEADACHES</small>
6. Feeling like he/she needs to throw up	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>FEELINGHUNGRY</small>
7. Going "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>GOINGLOW</small>
8. Going "high"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>GOINGHIGH</small>
9. Feeling tired	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>FEELINGTIRED</small>
10. Getting shaky	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>GETTINGSHAKY</small>
11. Getting sweaty	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>GETTINGSWEATY</small>
12. Feeling dizzy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>FEELINGDIZZY</small>
13. Feeling weak	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>FEELINGWEAK</small>
14. Having trouble sleeping	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>HAVINGTROUBLESLEEPING</small>
15. Getting cranky or grumpy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>GETTINGCRANKYORGRUMPY</small>

In the past **ONE month**, how much of a **problem** has your child had with ...

TREATMENT - I (problems with...)	Never	Almost Never	Some-Times	Often	Almost Always
1. Finger pricks causing him/her pain	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 FINGERPRICKSCAUSINGPAIN
2. Insulin shots causing him/her pain	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 INSULINSHOTSCAUSINGPAIN
3. Getting embarrassed about his/her diabetes treatment	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 GETTINGEMBARRASSEDABOUTTREATME
4. Arguing with me or my spouse about diabetes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 ARGUINGABOUTDIABETESCARE
5. It is hard for my child to do everything he/she needs to do to care for his/her diabetes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

Whether your child does these things **independently or with your help**, please answer how difficult these things were to do in the past **ONE month**. (Note: This section is **not** asking about your child's independence in these areas, just how hard they were to do).

TREATMENT - II (problems with...)	Never	Almost Never	Some-Times	Often	Almost Always
1. It is hard for my child to take blood glucose tests	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HARDTOTAKEBLOODGLUCOSETESTS
2. It is hard for my child to take insulin shots	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HARDTOTAKEINSULINSHOTS
3. It is hard for my child to play or do	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HARDTOPLAYSPORTS
4. It is hard for my child to track carbohydrates	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HARDFORCHILDTOTRACKCARBS
5. It is hard for my child to carry a fast-acting carbohydrate	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HARDFORCHILDTOCARRYCARB
6. It is hard for my child to snack when he/she goes "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HARDFORCHILDTOSNACKWHENLOW

In the past **ONE month**, how much of a **problem** has your child had with ...

WORRY (problems with...)	Never	Almost Never	Some-Times	Often	Almost Always
1. Worrying about going "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>WORRYINGABOUTGOINGLOW</small>
2. Worrying about going "high"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>WORRYINGABOUTGOINGHIGH</small>

In the past **ONE month**, how much of a **problem** has your child had with ...

COMMUNICATION (problems with...)	Never	Almost Never	Some-Times	Often	Almost Always
1. Telling the doctors and nurses how he/she feels	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>TELLINGDOCTORSHOWFEELS</small>
2. Asking the doctors or nurses questions	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>ASKINGDOCTORSQUESTIONS</small>
3. Explaining his/her illness to other people	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>EXPLAININGILLNESSTOPEOPLE</small>
4. Getting embarrassed about having diabetes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 <small>EMBARRASSEDABOUTHAVINGDIABETES</small>



Local Use Only

SubjectID

Office Use Only

Visit:

- Baseline 3 Months 6 Months 12 Months 24 Months 36 Months
- 48 Months 60 Months

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Protocol ID:

Date Questionnaire was Reviewed:

(DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

Local Use Only

30081

SubjectID

Pediatric Inventory for Parents

What is your relationship to the child? **RELATIONTOTEDDYCHILD**

- Mother
 Father
 Other Primary Caretaker
 Other, specify

Code (office use only)

--	--	--	--	--

Date you completed this questionnaire:

--	--	--	--	--	--	--	--	--	--

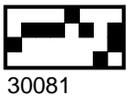
RELATIONTOTEDDYCHILDOTHERCODE

EVENT_AGE

(DD/MMM/YYYY - Example 01/JAN/2004)

Below is a list of difficult events which parents of children who have (or have had) a serious illness sometimes face. Please read each event carefully, and please fill in the circle HOW OFTEN the event has occurred for you in the past 7 days, using the 5 point scale below. Afterwards, please rate how DIFFICULT it was/or generally is for you, also using the 5 point scale. Please complete both columns for each item.

EVENT	HOW OFTEN?					HOW DIFFICULT?					
	1=Never,	2=Rarely,	3=Sometimes,	4=Often,	5=Very Often	1=Not at all,	2=A little,	3=Somewhat,	4=Very Much,	5=Extremely	
1. Difficulty sleeping DIFFICULTYSLEEPINGHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	DIFFICULTYSLEEPINGHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
2. Arguing with family member(s) ARGUINGWITHFAMILYHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	ARGUINGWITHFAMILYHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
3. Bringing my child to the clinic or hospital BRINGINGCHILDHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	BRINGINGCHILDHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
4. Learning upsetting news LEARNINGUPSETTINGNEWSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	LEARNINGUPSETTINGNEWSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
5. Being unable to go to work/job BEINGUNABLETOWORKHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	BEINGUNABLETOWORKHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
6. Seeing my child's mood change quickly SEEINGCHILDMOODCHANGEHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	SEEINGCHILDMOODCHANGEHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
7. Speaking with doctor SPEAKINGWITHDOCTORHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	SPEAKINGWITHDOCTORHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
8. Watching my child have trouble eating WATCHINGCHILDEATINGHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	WATCHINGCHILDEATINGHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
9. Waiting for my child's test results WAITINGTESTRESULTSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	WAITINGTESTRESULTSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
10. Having money/financial troubles HAVINGMONEYTROUBLESHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HAVINGMONEYTROUBLESHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
11. Trying not to think about my family's difficulties TRYINGNOTTOTHINKHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	TRYINGNOTTOTHINKHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
12. Feeling confused about medical information FEELINGCONFUSEDHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	FEELINGCONFUSEDHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
13. Being with my child during medical procedures BEINGWITHDURINGHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	BEINGWITHDURINGHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
14. Knowing my child is hurting or in pain KNOWINGCHILDPAINHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	KNOWINGCHILDPAINHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
15. Trying to attend to the needs of other family members TRYINGATTENDNEEDSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	TRYINGATTENDNEEDSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
16. Seeing my child sad or scared SEEINGCHILDSADHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	SEEINGCHILDSADHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
17. Talking with the nurse TALKINGNURSEHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	TALKINGNURSEHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
18. Making decisions about medical care or medicines MAKINGDECISIONSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	MAKINGDECISIONSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
19. Thinking about my child being isolated from others THINKINGCHILDISOLATEDHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	THINKINGCHILDISOLATEDHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
20. Being far away from family and/or friends BEINGFARAWAYHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	BEINGFARAWAYHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
21. Feeling numb inside FEELINGNUMBHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	FEELINGNUMBHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
22. Disagreeing with a member of the health care team DISAGREEINGHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	DISAGREEINGHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5



30081

Local Use Only

[Empty box for Local Use Only]

SubjectID

[Empty box for SubjectID]

EVENT	HOW OFTEN?					HOW DIFFICULT?					
	1=Never,	2=Rarely,	3=Sometimes,	4=Often,	5=Very Often	1=Not at all,	2=A little,	3=Somewhat,	4=Very Much,	5=Extremely	
23. Helping my child with his/her hygiene needs HELPINGHYGIENENEEDSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HELPINGHYGIENENEEDSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
24. Worrying about the long term impact of the illness WORRYINGIMPACTHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	WORRYINGIMPACTHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
25. Having little time to take care of my own needs HAVINGLITTLETIMEHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HAVINGLITTLETIMEHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
26. Feeling helpless over my child's condition FEELINGHELPLESSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	FEELINGHELPLESSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
27. Feeling misunderstood by family/friends as to the severity of my child's illness FEELINGMISUNDERSTOODHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	FEELINGMISUNDERSTOODHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
28. Handling changes in my child's daily medical routines .. HANDLINGCHANGESHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HANDLINGCHANGESHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
29. Feeling uncertain about the future FEELINGUNCERTAINHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	FEELINGUNCERTAINHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
30. Being in the hospital over weekends/holidays HOSPITALWEEKENDSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HOSPITALWEEKENDSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
31. Thinking about other children who have been seriously ill THINKINGSERIOUSLYHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	THINKINGSERIOUSLYHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
32. Speaking with my child about his/her illness..... SPEAKINGWITHCHILDHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	SPEAKINGWITHCHILDHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
33. Helping my child with medical procedures (e.g. giving shots, swallowing medicine, changing dressing) HELPINGCHILDPROCEDURESHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HELPINGCHILDPROCEDURESHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
34. Having my heart beat fast, sweating, or feeling tingly HEARTBEATFASTHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	HEARTBEATFASTHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
35. Feeling uncertain about disciplining my child UNCERTAINDISCIPLININGHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	UNCERTAINDISCIPLININGHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
36. Feeling scared that my child could get very sick or die FEELINGSCAREDCHILDDIEHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	FEELINGSCAREDCHILDDIEHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
37. Speaking with family members about my child's illness SPEAKINGABOUTILLNESSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	SPEAKINGABOUTILLNESSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
38. Watching my child during medical visits/procedures WATCHINGCHILDPROCEDURESHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	WATCHINGCHILDPROCEDURESHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
39. Missing important events in the lives of other family members MISSINGIMPORTEVENTSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	MISSINGIMPORTEVENTSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
40. Worrying about how friends and relatives interact with my child ... WORRYINGABOUTINTERACTHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	WORRYINGABOUTINTERACTHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
41. Noticing a change in my relationship with my partner NOTICINGCHANGEPARTNERHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	NOTICINGCHANGEPARTNERHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
42. Spending a great deal of time in unfamiliar settings UNFAMILIARSETTINGSHOWOFTEN	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	UNFAMILIARSETTINGSHOWDIFFICULT	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5



30081

Local Use Only

SubjectID

Office Use Only

Visit: VISIT

- Baseline 3 Months 6 Months 12 Months 24 Months 36 Months
- 48 Months 60 Months

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Protocol ID:

Date Questionnaire was Reviewed:

(DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

English Teleform

German Teleform

The Environmental Determinants of Diabetes in the Young**Physical Examination Form****Clinic Visit**

* These fields are required in order to SAVE the form.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Valid date range for this visit : **28 Mar 2007** until **27 Jun 2007**.

Date Of Exam	724 725 726 *	Visit Location Code	*
Visit Months	OR	TEDDY Staff Code	*
Visit Years	670 months OR 671 years		

1) Please record the TEDDY child's weight and length/height. The infant should be weighed lying on his/her back without clothes and diaper. Children old enough to stand on a scale should be measured in light clothing. Length is measured on all children up to two years old. It should be measured with the child lying on his/her back from heels (without shoes) to the top of the head. After the child is two years old the standing height should be measured with the child standing, without shoes.

a) Weight	659 kilograms	Weight
b) Length/Height	660 centimeters	LengthHeight
<input checked="" type="radio"/> Weight & Length/Height collected by long-distance protocol 2213 WeightLengthLongDistanceProtocol		
<input checked="" type="radio"/> By Healthcare Professional 3575 WhoCollectedLongDistanceProtocol		
<input type="radio"/> By Parent		

If Weight & Length/Height were collected by long-distance protocol indicate the date of measurement below: 3113 3114

3115 DateMeasurementMonth DateMeasurementDay DateMeasurementYear

<input checked="" type="radio"/> Weight & Length/Height collected by Non-standard TEDDY protocol 3517 WeightLengthNonStandardProtocol		
<input checked="" type="radio"/> By Healthcare Professional 3518 WhoCollectedNonStandardProtocol		
<input type="radio"/> By Parent		
<input type="radio"/> By Teddy staff member		

If Weight & Length/Height were collected by non-standard TEDDY protocol indicate the date of measurement below:

3576 3577 3578 DateMeasurementDayNonStandard DateMeasurementMonthNonStandard DateMeasurementYearNonStandard

2) Below please record the amount of blood drawn, the draw site and the date and time the sample was drawn and the date it was shipped:

a) Total Amount of blood drawn	661 mL	AmountBloodDrawn
b) Draw Site (mark either Venous or Capillary - mark only 1 site where blood was drawn from):		
<input checked="" type="radio"/> Venous <input type="radio"/> Capillary 662 DrawSite		
<input type="radio"/> Left antecubital <input type="radio"/> Right antecubital <input checked="" type="radio"/> Left Hand 663 <input type="radio"/> Right Hand <input type="radio"/> Other	<input checked="" type="radio"/> Left Heel <input type="radio"/> Right Heel <input type="radio"/> Finger 664 <input type="radio"/> Other	
* Section 2c to be completed by remote lab only.		

* c) Date Sample was Drawn 2120 2121 2122 DaySampleDrawn MonthSampleDrawn YearSampleDrawn

Time Sample was Drawn	2126	Please record time in Universal Time - for example 2 pm would be recorded as 14:00	hh:mm
TimeSampleDrawn			

Date Sample was Shipped 2123 2124 2125 DaySampleShipped MonthSampleShipped YearSampleShipped

3) Please record if the family was referred to another healthcare specialist: 665 AnotherHealthcareSpecialist

Yes No

a) Date of referral	666 667 668
---------------------	-------------

DateReferralDay DateReferralMonth DateReferralYear

b) Referral Reason	669	Referral_Reason
***If child tests positive for any Autoantibody, a random plasma/blood glucose test will be done at every visit. Please record the blood glucose level and draw site below.		
Blood glucose level	<input type="text" value="2078"/> mg/dLOR <input type="text" value="2083"/> mmol/l	BloodGlucoseLevel_mmolPerLitre
Draw site	<input checked="" type="radio"/> Venous Blood <input type="radio"/> Capillary Blood 2079 <input type="radio"/> Venous Plasma	DrawSite2
4) Has the subject participated in a new research study (other than TEDDY) since his/her last TEDDY visit or is the subject still participating in another study that has been previously indicated on the "Participant in Non-TEDDY Research Form"?		
<input checked="" type="radio"/> Yes <input type="radio"/> No 2235		
If yes, please complete a new "Participant in Non-TEDDY Research Form".		
Comments	<input type="text" value="2240"/> ExamComments	
<input type="button" value="Save"/>	<input type="button" value="Print"/>	<input type="button" value="Close"/>

Positive Transglutaminase Antibody Follow-Up/Biopsy Form

* These fields are required in order to SAVE the form.

Interview Date	<input type="text"/> <input type="text"/> <input type="text"/> *	Visit Location Code	<input type="text"/> *
TEDDY Staff Code of Interviewer <input type="text"/> *			
Did the parents receive TEDDY printed information about Celiac disease? 3811			
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know ParentsReceiveInfoAbout Diagno			
Did the parents receive information about family risk of Celiac disease? 3812			
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know DidParentsReceiveInfoAboutCel			

This form should be completed on all children who have persistent* positive Transglutaminase antibodies or who were diagnosed with Celiac disease outside of the TEDDY study. More than one form should be submitted if biopsies have been performed on several occasions or the biopsy data has changed.

***Persistent is defined as having two consecutive TGA positive samples at any time.**

1. Was an intestinal biopsy performed?

- | | | |
|----------------------------------|--|------|
| <input type="radio"/> Yes | (if yes, complete question 2 and then form completion is done) | 4179 |
| <input type="radio"/> No | (if no, complete question 3 and then form completion is done) | |
| <input type="radio"/> Don't Know | (if don't know then form completion is done) | |
- Intestinalbiopsyperformed**

2. If **YES**, complete the following:

- a. Date of Biopsy (DD/MMM/YYYY) event_age
- b. Age at biopsy years months
- c. Biopsy procedure: **AgeAtBiopsyInYears** **AgeAtBiopsyInMonth**
- Single intestinal biopsy by Watson capsula Yes No Don't Know 3636 **SinIntestiBiopsyByWatCap**
- Serial biopsies by upper endoscopy Yes No Don't Know 3637 **SerialBiopByUppEndos**
- d. Provider/facility where biopsy was done **WhereBiopsyWasDoneLine1**
 WhereBiopsyWasDoneLine2
 WhereBiopsyWasDoneLine3
- e. Do we have signed medical release? Yes No Don't Know 3638 **HaveSignedMedicalRelease**
- f. Biopsy result after histological classification (or corresponding to Marsh score) (choose one option) 3639 **BiopsyResultAftHistoClassifi**
- Normal mucosa (Marsh 0)
- Increased intra-epithelial lymphocyte (IEL) count only (i.e. >25 IEL/100 enterocytes) (Marsh 1)
- Increased IELs; crypt hyperplasia; normal villous structure (Marsh 2)
- Mild villous flattening (partial villous atrophy); increased IELs; crypt hyperplasia (Marsh 3a)
- Marked villous flattening (subtotal villous atrophy); increased IELs; crypt hyperplasia (Marsh 3b)
- Flat mucosa (total villous atrophy); increased IELs; crypt hyperplasia (Marsh 3c)
- Flat mucosa (total villous atrophy); increased IELs; normal crypt height (Marsh 4)
- Result unknown, inconclusive, insufficient sample

3. If **NO**, why was a biopsy not performed? (mark all that apply) 3813

- The parents refused biopsy despite positive TGA **WHYBIOPSYNOTPERFORME_THEPARENTSR**
WhyBiopsyNotPerformed
- The pediatrician refused biopsy despite positive TGA **WHYBIOPSYNOTPERFORME_THEPEDIATRI**
- The child had no symptoms **WHYBIOPSYNOTPERFORME_THECHILDHAD**
- The child was placed on gluten-free diet without biopsy **WHYBIOPSYNOTPERFORME_THECHILDWAS**
Confirm/document gluten free diet stop/start dates on TEDDY data extraction form
- The biopsy would be too expensive **WHYBIOPSYNOTPERFORME_THEBIOPSYWO**
- Other Reason **WHYBIOPSYNOTPERFORME_OTHERREASON**

Code **CodeWhyBiopsyNotPerform**

English Teleform

German Teleform

Swedish Teleform

Finnish Teleform

Spanish Teleform

TEDDY

The Environmental Determinants of Diabetes in the Young

First TEDDY Study Questionnaire

(Primary Care Taker)

* These fields are required in order to SAVE the form.
 * These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Day Form was Reviewed	<input type="text"/> <input type="text"/> <input type="text"/> * 99, 100, 101	Visit Location Code	<input type="text"/> *
TEDDY Staff Code	<input type="text"/> *	Relationship to child of person filling out questionnaire (code):	688

1. Date you completed this questionnaire: 102103104*

Below are two questions about the child's birth mother's history of diabetes. If you do not know the answer to a question, fill in the circle "Don't Know".

86 2. Did the child's birth mother have gestational diabetes during pregnancy?*

No Yes Don't Know GestationalDiabetes

87 3. Does the child's birth mother have Type 1 or Type 2 diabetes?*

No Yes, Type 1 Yes, Type 2 Don't know

Type1orType2

We are interested in your reactions to this baby's genetic test result and your experiences in the TEDDY Study.

88 4. Compared to other children, do you think this child's risk for developing diabetes is:
 (Mark one answer) ChildsRiskForDiabetes

Much Lower Somewhat lower About the same Somewhat higher Much higher

89 5. When you think about this baby's future, do you think:(Mark one answer)

The child will develop diabetes in the near future
 The child will eventually develop diabetes but a long time from now
 The child will never develop diabetes BabysFutureDoYouThink
 You're unsure what will happen

90 6. When you think about this baby's risk for developing diabetes do you feel:(Mark one answer on each line a-f)

91 a. Not at all calm Somewhat calm Moderately calm Very calm BabysRiskDiabetesFeelCalm

92 b. Not at all worried Somewhat worried Moderately worried Very worried BabysRiskDiabetesFeelWorried

93 c. Not at all relaxed Somewhat relaxed Moderately relaxed Very relaxed BabysRiskDiabetesFeelRelaxed

94 d. Not at all tense Somewhat tense Moderately tense Very tense BabysRiskDiabetesFeelTense

95 e. Not at all at-ease Somewhat at-ease Moderately at-ease Very at-ease BabysRiskDiabetesFeelEase

96 f. Not at all nervous Somewhat nervous Moderately nervous Very nervous BabysRiskDiabetesFeelNervous

96 7. Overall, how do you feel having the baby genetically tested for diabetes risk? BabysGeneticTestDiabetesFeelin

Liked it a lot Liked it a little It was OK Disliked it a little Disliked it a lot

97 8. Do you think having the baby genetically tested was a good decision? BabyGeneticTestGoodDecision

A great decision A good decision An OK decision A bad decision A very bad decision

98 9. If a friend was pregnant, would you recommend she have her baby genetically tested for diabetes risk?

RecommendGeneticTest

No Yes Maybe

Local Use Only



16732

SubjectID

TEDDY Tanner Stage - Female (≥ 8 years)

Office Use Only

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Date Questionnaire Was Reviewed:

 / /
 (DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

Visit:

 8 year 12 year**TannerVisit** 8 year 6 month 12 year 6 month 9 year 13 year 9 year 6 month 13 year 6 month 10 year 14 year 10 year 6 month 14 year 6 month 11 year 15 year 11 year 6 month 15 year 6 month

Local Use Only



16732

SubjectID

TEDDY Tanner Stage -- Female (≥ 8 years)

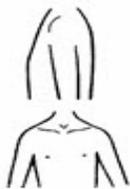
1. Date you completed this questionnaire:

 / /

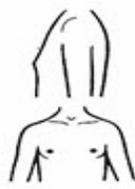
(DD/MMM/YYYY - Example 01/JAN/2004)

TannerStageofBreastDevelopment

2. Girls go through normal changes as they get older. Please LOOK at the drawings and read the sentences below each of them. Then choose the drawing closest to your (your child's) stage of breast development and FILL IN THE CIRCLE above it.

 Stage 1

1. There is no difference from the childhood look.
2. The nipple is raised a little.
3. The rest of the breast is still flat.

 Stage 2

1. The breast is a little larger and the nipple is raised more than Stage 1.
2. The darker skin area of the nipple is larger than in Stage 1.

 Stage 3

1. The darker skin area around the nipple and the breast are both larger than Stage 2.
2. The darker skin area around the nipple does not stick out away from the breast.

 Stage 4

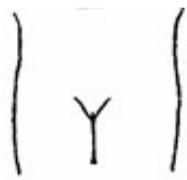
1. The darker skin area around the nipple and the nipple stick up above the shape of the breast.

 Stage 5

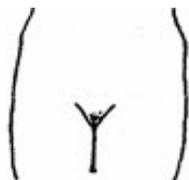
1. Only the nipple sticks out in this stage.
2. The darker skin area around the nipple has moved back down to the breast.

TannerStageofFemalePubicHairDe

3. Please LOOK at the drawings and read the sentences below each of them. Then choose the drawing closest to your (your child's) stage of pubic hair development and FILL IN THE CIRCLE above it.

 Stage 1

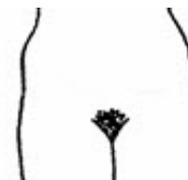
1. There is no pubic hair

 Stage 2

1. There is a little, long, lightly colored hair, only on both sides of the genitals.
2. This hair may be straight or a little curly

 Stage 3

1. The hair is darker, coarser and more curled.
2. It has spread out and thinly covers a larger area, above the genitals.

 Stage 4

1. The hair is now as dark, curly, and coarse as that of a grown woman.
2. The hair has not spread out to the legs and the area has rounded corners.

 Stage 5

1. The hair is now like that of a grown woman.
2. The hair often forms a triangle and it may spread out to the legs.

4. Have you started your period? Yes No**Have you started your period**

If Yes, Date of First Period:

 / /

(DD/MMM/YYYY - Example 01/JAN/2004)

Date of First Period Day**Date of First Period Month****Date of First Period Year**



22714

Local Use Only

SubjectID

TEDDY Tanner Stage - Boys (≥ 8 years)

Office Use Only

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

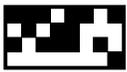
Date Questionnaire Was Reviewed:

(DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

- Visit:**
- TannerVisit**
- 8 year
 - 8 year 6 month
 - 9 year
 - 9 year 6 month
 - 10 year
 - 10 year 6 month
 - 11 year
 - 11 year 6 month
 - 12 year
 - 12 year 6 month
 - 13 year
 - 13 year 6 month
 - 14 year
 - 14 year 6 month
 - 15 year
 - 15 year 6 month



22714

Local Use Only

SubjectID

TEDDY Tanner Stage -- Boys(≥ 8 years)

DateQuestionnairewasReviewedDa DateQuestionnairewasReviewedMo DateQuestionnairewasReviewedYe

1. Date you completed this questionnaire:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------	---	----------------------	----------------------	----------------------	----------------------

(DD/MMM/YYYY - Example 01/JAN/2004)

TannerStageofBoyDevelopment

2. Boys go through normal changes as they get older.

Please **LOOK** at the drawings and read the sentences below each of them. Then choose the drawing closest to your (your child's) stage of development and **FILL IN THE CIRCLE** above it.

Stage 1

Stage 2

Stage 3

Stage 4

Stage 5



1. There is no pubic hair.
2. There is no difference from the childhood look.

1. There is a little soft, long, lightly colored hair.
2. Most of the hair is at the base of the penis.
3. This hair may be straight or a little curly.

1. The hair is darker, coarser and more curled.
2. It has spread out and thinly covers a larger area.

1. The hair is now as dark, curly, and coarse as that of a grown man.
2. The hair has not spread out to the thighs and the corners of the hair area is still rounded.

1. The hair is now like in adults. The area is triangular in shape.
2. The hair may spread out to the thighs.

TEDDY
The Environmental Determinants of Diabetes in the Young
Infant Screening Form

* These fields are required in order to SAVE the form.
* These additional fields are required in order to make the form complete.

Date of Screening (dd mm yy) [2009] **Child's Date of Birth** (dd mm yy) [2009]

Local Code [] **Clinical Center** []

TEDDY Staff Code (of Interviewer) [] **Visit Location Code** []

Subject Id: []

Has the child's parent(s) or legal guardian(s) given signed informed consent for the child to be screened? *
 No Yes **InformedConsent**

Child's Information

Sex: Male Female Singleton Twin Triplet Other

Races (check all that apply)*
 White Black or African American Asian Native Hawaiian, or other Pacific Islander Native American, Alaskan Native, Aboriginal Canadian, Aboriginal Australian Unknown or not reported

Ethnicity: *
 Is this child of Hispanic, Latino, or Spanish origin?
 No Yes Unknown or not reported

MomDOBYear [] **FatherDOBYear** []

What is the mother's highest grade or level of schooling completed?
(For US and Germany)
 Grades 1-9 Grades 10-12 Graduated High School or awarded a GED Some trade school Graduated from trade school Some college or university Graduated with a bachelor's degree (for example BA, AB or BS degrees) Some graduate or professional school Graduated with a master's degree (for example MA, MS, MBA, MEng, MEd, MSW) Graduated with a doctoral degree (for example MD, DDS, JD, Ph.D., Ed.D degree)

(For Finland)
 Grades 1-9 Grades 10-12/high school Graduated from high school Some trade school Graduated from trade school Some polytechnic/college Graduated from polytechnic/college Studied in the university University degree Doctor's degree

(For Sweden)
 Not finished basic education Finished basic education Not finished high school Finished vocationally oriented high school Finished other high school Vocational education outside high school Not finished college/university Graduated from college or university Ongoing graduate studies Finished PhD

Is this child the mother's first child? **MomFirstChild**
 No Yes

Family History of Type 1 Diabetes*
 Does this child have any family members with Type 1 Diabetes? No Yes Unknown
 If yes, who? Mother Father Sibling **WHICHFAMILYMEMT1D_Mother**
 Other **WHICHFAMILYMEMT1D_Father**
 Sibling **WHICHFAMILYMEMT1D_SIBLING**

Study History
 Does this family have other children already enrolled in this study? No Yes **OtherChildEnrolled**
 If "Yes", please provide other children's Local Code(s):
 [] **OTHERCHILDMASKID#_1**
 []
 [] **MomEnrolledPregStudy**
 Was the Mother involved in the pregnancy study? * No Yes **Mom_MaskID**
 If "Yes", please provide Mother's Local Code: []

HLA Sample Information*
HLADrawAge [] **HLASampleNumber** []

Sample draw date: [2009] HLA Screening Sample Number: []

[Save] [Print] [Clear] [Close]

Event_age

Race_White

Race_BlackorAfricanAmerica

Race_Asian

Race_NativeHawaianorOtherPacific

Race_NativeAmericanAlaskanNative

Race_Unknownornotreported

MomDOBYear

FatherDOBYear

MomSchoolingCompleted

MomSchoolingCompletedFin

MomSchoolingCompletedSwe

MomFirstChild

FDR

WHICHFAMILYMEMT1D_Mother

WHICHFAMILYMEMT1D_Father

WHICHFAMILYMEMT1D_SIBLING

OtherChildEnrolled

OTHERCHILDMASKID#_1

MomEnrolledPregStudy

Mom_MaskID

HLADrawAge

HLASampleNumber

English Teleform

German Teleform

Swedish Teleform

Finnish Teleform

Spanish Teleform

TEDDY**The Environmental Determinants of Diabetes in the Young****Primary Caretaker Questionnaire****6 Month Clinic Visit**

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Date Questionnaire Reviewed	1144	1145	1146 *	Visit Location Code		*
TEDDY Staff Code		*				

1. Date you completed this questionnaire:

 * event_age

2. What is your relationship to the TEDDY child?* ¹¹⁴⁷ RelationshipToChild <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Other Primary Caretaker <input type="radio"/> Other Code <input type="text" value="1157"/> RelationToChildCode	
3. Compared to other children, do you think your child's risk for developing diabetes is: ¹¹⁴⁸ ChancesofDiabetes <input type="radio"/> Much lower <input type="radio"/> Somewhat lower <input type="radio"/> About the same <input type="radio"/> Somewhat higher <input type="radio"/> Much higher	
4. When you think about your baby's future, do you think: ¹¹⁴⁹ YourFeelingBabyFuture <input type="radio"/> Your child will develop diabetes in the near future <input type="radio"/> Your child will eventually develop diabetes but a long time from now <input type="radio"/> Your child will never develop diabetes <input type="radio"/> You're unsure what will happen	
5. How often do you worry that your child will get diabetes? ¹¹⁵⁰ YourWorryForChildsDiabetes <input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Often <input type="radio"/> Very often	
6. When you think about your baby's risk for developing diabetes, you feel:	
a.	<input type="radio"/> Not at all calm <input type="radio"/> Somewhat calm <input type="radio"/> Moderately calm <input type="radio"/> Very calm FeelingBabyRiskDiabetesCalm ¹¹⁵¹
b.	<input type="radio"/> Not at all worried <input type="radio"/> Somewhat worried <input type="radio"/> Moderately worried <input type="radio"/> Very worried UFeelBabyRiskDiabetesWorry ¹¹⁵²
c.	<input type="radio"/> Not at all relaxed <input type="radio"/> Somewhat relaxed <input type="radio"/> Moderately relaxed <input type="radio"/> Very relaxed UFeelBabyRiskDiabetesRelax ¹¹⁵³
d.	<input type="radio"/> Not at all tense <input type="radio"/> Somewhat tense <input type="radio"/> Moderately tense <input type="radio"/> Very tense UFeelBabyRiskDiabetesTense ¹¹⁵⁴
e.	<input type="radio"/> Not at all at-ease <input type="radio"/> Somewhat at-ease <input type="radio"/> Moderately at-ease <input type="radio"/> Very at-ease UFeelBabyRiskDiabetesEase ¹¹⁵⁵
f.	<input type="radio"/> Not at all nervous <input type="radio"/> Somewhat nervous <input type="radio"/> Moderately nervous <input type="radio"/> Very nervous UFeelBabyRiskDiabetesNervous ¹¹⁵⁶

7. Some parents get the baby blues after birth of the child. Here are some questions about the baby blues. Please think about the time since this child was born for each question and then mark an answer.*

a. You have been able to laugh and see the funny side of things *

- As much as I always could
 Not quite so much now
 Definetely not so much now
 Not at all

1158

WhenDoSeeFunnySideOfThings

b. You have looked forward with enjoyment to things*

- As much as I always did
 Rather less than I used to
 Definetely less than I used to
 Hardly at all

1159

YouLookForwardToEnjoyThings

c. You have blamed yourself unnecessarily when things went wrong*

- Most of the time Some of the time Not very often Never

1160

BlameYourselfThingsWentWrong

d. You have been anxious and worried for no good reason*

- Not at all Hardly ever Sometimes Very often

1161

AnxiousWorryForNoReason

e. You have felt scared or panicky for no very good reason*

- Quite a lot Sometimes Not much Not at all

1162

ScaredPanickyForNoReason

f. Things have been getting on top of you*

- Most of the time you haven't been able to cope at all
 Sometimes you haven't been coping as well as usual
 Most of the time you have coped quite well
 You have been coping as well as ever

1163

WhenThingsGetOnTopOfYou

g. You have been so unhappy that you have had difficulty sleeping*

- Most of the time Sometimes Not very often Never

1164

BeenUnhappyDifficultSleeping

h. You have felt sad and miserable*

- Most of the time Some of the time Not very often Never

1165

FeltSadandMiserable

i. You have been so unhappy that you have been crying*

- Most of the time Quite often Only occasionally Never

1166

BeenUnhappyCrying

j. The thought of harming yourself has occurred to you*

- Quite often Sometimes Hardly ever Never

1167

ThoughtOfHarmingYourself

8. Please read each statement below and mark whether you agree or disagree with the statement.

a. I can do something to reduce my child's risk of developing diabetes

- Strongly agree Agree Neutral Disagree Strongly disagree

1168

ICanReduceChildriskDiabetes

b. Medical professionals can do something to reduce my child's risk of developing diabetes

- Strongly agree Agree Neutral Disagree Strongly disagree

1169

MedProfReduceChildRiskDiabetes

c. It is up to chance or fate whether my child develops diabetes

- Strongly agree Agree Neutral Disagree Strongly disagree

1170

ChildDiabetesChanceOrFate

9. Sometimes people do things to try to stop their child from getting diabetes. Sometimes people do nothing special to try to prevent diabetes in the child. Have you done anything to try to stop or prevent your child from getting diabetes?*

No Yes 1171

HaveDoneAnythingStopDiabetes

If you answered **Yes**, what kinds of things have you done to try and stop or prevent diabetes in your child?

a. Code	<input type="text" value="1172"/>	WhatDidYouDoCode1
b. Code	<input type="text" value="1173"/>	WhatDidYouDoCode2
c. Code	<input type="text" value="1174"/>	WhatDidYouDoCode3
d. Code	<input type="text" value="1175"/>	WhatDidYouDoCode4
e. Code	<input type="text" value="1176"/>	WhatDidYouDoCode5
Code	<input type="text" value="3572"/>	
	<input type="text"/>	
	<input type="button" value="Add"/>	

10. Have you done anything to monitor or keep an eye on your child's risk of developing diabetes?*

No Yes 1177

DoneAnyToMonitorRiskDiabetes

If you answered **Yes**, what kind of things have you done to monitor or keep an eye on your child's risk for developing diabetes?

a. Code	<input type="text" value="1178"/>	DoneAnyToMonitorCode1
b. Code	<input type="text" value="1179"/>	DoneAnyToMonitorCode2
c. Code	<input type="text" value="1180"/>	DoneAnyToMonitorCode3
d. Code	<input type="text" value="1181"/>	DoneAnyToMonitorCode4
e. Code	<input type="text" value="1182"/>	DoneAnyToMonitorCode5

11. Overall, how do you feel about having your child participate in the TEDDY study?	FeelingOfParticipationInTEDDY	1183
<input type="radio"/> Like it a lot <input type="radio"/> Like it a little <input type="radio"/> It is OK <input type="radio"/> Dislike it a little <input type="radio"/> Dislike it a lot		
12. Do you think your child's participation in the TEDDY study was a good decision?	DecidingChildParticipationTEDDY	1184
<input type="radio"/> A great decision <input type="radio"/> A good decision <input type="radio"/> An OK decision <input type="radio"/> A bad decision <input type="radio"/> A very bad decision		
13. Would you recommend the TEDDY study to a friend?	RecommendTeddyStudyFriend	1185
<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe		

Local Use Only

SubjectID

STAI (for children 8 years & older)

Date you completed this questionnaire:

		/				/			
--	--	---	--	--	--	---	--	--	--

event_age

(DD/MMM/YYYY - Example 01/JAN/2004)

When you think about you having diabetes, you feel:
(Mark one statement on each line a-f)

a.	<input type="radio"/> Not at all calm	<input type="radio"/> Somewhat calm	<input type="radio"/> Moderately calm	<input type="radio"/> Very calm	STAICHILDRENCALM
b.	<input type="radio"/> Not at all worried	<input type="radio"/> Somewhat worried	<input type="radio"/> Moderately worried	<input type="radio"/> Very worried	STAICHILDRENWORRIED
c.	<input type="radio"/> Not at all relaxed	<input type="radio"/> Somewhat relaxed	<input type="radio"/> Moderately relaxed	<input type="radio"/> Very relaxed	STAICHILDRENRELAXED
d.	<input type="radio"/> Not at all tense	<input type="radio"/> Somewhat tense	<input type="radio"/> Moderately tense	<input type="radio"/> Very tense	STAICHILDRENTENSE
e.	<input type="radio"/> Not at all at-ease	<input type="radio"/> Somewhat at-ease	<input type="radio"/> Moderately at-ease	<input type="radio"/> Very at-ease	STAICHILDRENATEASE
f.	<input type="radio"/> Not at all nervous	<input type="radio"/> Somewhat nervous	<input type="radio"/> Moderately nervous	<input type="radio"/> Very nervous	STAICHILDRENNERVOUS



4273

Local Use Only

SubjectID

Office Use Only

visit

Visit:

- Baseline 3 Months 6 Months 12 Months 24 Months 36 Months
- 48 Months 60 Months

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Protocol ID:

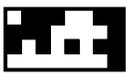
Date Questionnaire was Reviewed:

 / /

(DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:



57771

Local Use Only

SubjectID

STAI and Well-Being Question (for parents)

Date you completed this questionnaire:

 / /

event_age

(DD/MMM/YYYY - Example 01/JAN/2004)

RELATIONSHIPTOCHILD_MOTHERFATHER

What is your relationship to the child?

RELATIONSHIPTOCHILD_OTHERPRIMARY

 Mother Father Other Primary Caretaker Other, specify

RELATIONSHIPTOCHILD_OTHER

RELATIONSHIPTOCHILD_FATHER

RELATIONSHIPTOCHILD_MOTHER

Code (office
use only)

RELATIONSHIPTOCHILDCODE

1. When you think about your child having diabetes, you feel:
(Mark one statement on each line a-f)

STAIPARENTSCALM

a. Not at all calm Somewhat calm Moderately calm Very calm

STAIPARENTSWORRIED

b. Not at all worried Somewhat worried Moderately worried Very worried

STAIPARENTSRELAXED

c. Not at all relaxed Somewhat relaxed Moderately relaxed Very relaxed

STAIPARENTSTENSE

d. Not at all tense Somewhat tense Moderately tense Very tense

STAIPARENTSATEASE

e. Not at all at-ease Somewhat at-ease Moderately at-ease Very at-ease

STAIPARENTSNERVOUS

f. Not at all nervous Somewhat nervous Moderately nervous Very nervous

2. How often do you feel that each phrase applies to you in the past few weeks?
(Mark one answer on each line a-f):

a. I feel that I am useful and needed: WELLBEINGUSEFUL

 All of the time Some of the time Occasionally Not at all

b. I have crying spells or feel like it: WELLBEINGCRYINGSPELLS

 All of the time Some of the time Occasionally Not at all

c. I find I can think quite clearly: WELLBEINGTHINKCLEARLY

 All of the time Some of the time Occasionally Not at all

d. My life is pretty full: WELLBEINGLIFEPRETTYFULL

 All of the time Some of the time Occasionally Not at all

e. I feel downhearted and blue: WELLBEINGDOWNHEARTED

 All of the time Some of the time Occasionally Not at all

f. I enjoy things I do: WELLBEINGENJOYTHINGS

 All of the time Some of the time Occasionally Not at all



57771

Local Use Only

SubjectID

Office Use Only

Visit: VISIT

- Baseline
- 3 Months
- 6 Months
- 12 Months
- 24 Months
- 36 Months
- 48 Months
- 60 Months

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Protocol ID:

Date Questionnaire was Reviewed:

(DD/MMM/YYYY - Example 01/JAN/2004)

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

Tracking Form

Symptoms of Celiac Disease

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Valid date range for this visit : **02 Dec 2010** until **01 Sep 2011**.

Interview Date	<input type="text"/> / <input type="text"/> / <input type="text"/> *	Visit Location Code	<input type="text"/> *
Visit Months OR Visit Years	<input type="text"/> months OR <input type="text"/> years	TEDDY Staff Code of Interviewer	<input type="text"/> *

Since the last time we completed this form, has your child had or is currently having any of the following problems? (Mark all that apply)

Problems	Yes
No symptoms Nosymptoms	<input type="checkbox"/> 4198
Chronic constipation (i.e. <3 stools per week) Chronicconstipation	<input type="checkbox"/> 4199
Frequent loose stools (i.e. >= 3 stools per day) Frequentloosestools	<input type="checkbox"/> 4200
Vomiting Vomiting2	<input type="checkbox"/> 4201
Abdominal discomfort (i.e. being gassy, bloated, or complaining of pain) AbdominalDiscomfort	<input type="checkbox"/> 4202
Poor Growth PoorGrowth	<input type="checkbox"/> 4203
Fatigue Fatigue2	<input type="checkbox"/> 4204
Irritability Irritability2	<input type="checkbox"/> 4205
Dental enamel defects (Pits/ lines in teeth) Dentalenemaldefects	<input type="checkbox"/> 4206
Ataxia (i.e. unsteady movements) Ataxia	<input type="checkbox"/> 4208
Anemia (i.e. low iron in blood) Anemia2	<input type="checkbox"/> 4209
Other Other2	<input type="checkbox"/> 4210
ICD-10 code ICDCodeOtherProblem	
<input type="text"/> 4211 ICDcodeforotherProblem	

TEDDY Update Form

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Visit Location Code *

COMPLETED CONTACT:

Type of contact: TypeOfContact Mail Email Phone In Person

Date of Interview/Date Form was Reviewed: event_age completeformage

TEDDY Staff Code *

INCOMPLETE CONTACT:

Date of Contact Attempt contactattemptage

Status of contact attempt:	Mail/Email	
	4141	<input type="checkbox"/> Sent, not returned StatusContactAttempt_Sentnotretu
		<input type="checkbox"/> Returned, not filled out StatusContactAttempt_Returnednot
		<input type="checkbox"/> Contact attempted, no response StatusContactAttempt_Contactatte
		<input type="checkbox"/> Unable to contact, no valid contact information StatusContactAttempt_Unabletocon
Phone		

PERMISSION TO CONTACT:

5242 Participant requested NO FUTURE CONTACT ParticipantrequestedNOFUTURECO
 (check this only if the family requests that we not contact them again)

1. Date you completed this questionnaire:

4117 2. What is your relationship to the TEDDY child? RelationToTEDDYChild

Mother
 Father
 Other Primary Caretaker
 Other
 Code: RelationToTEDDYChildOtherCode

We last had contact with you on: lastcontactage

Keep this date in mind for the following questions.

4122 3. Since our last contact with you, has your child been diagnosed with type 1 diabetes? Yes No ChildDiagnosedT1DM

IF YES:

a. What was the date of diagnosis of diabetes? t1dmdxage

b. If your child has been diagnosed with diabetes, has insulin been started? Yes No Unknown HasInsulinBeenStarted

4126 4. Since our last contact with you, has you child been diagnosed with celiac disease? Yes No HasBeenDiagnosedCeliacDisease

IF YES:

a. What was the date of diagnosis of celiac disease?

Sometimes circumstances change where inactive participants are interested in re-engaging in regular TEDDY visits or past participants are interested in re-joining the TEDDY Study.

4131 5. Would you like to have TEDDY contact you about re-activating or re-joining? Yes No LikeToRejoin

English Teleform	Swedish Teleform	German Teleform	Finnish Teleform	Spanish Teleform
------------------	------------------	-----------------	------------------	------------------

TEDDY

The Environmental Determinants of Diabetes in the Young

Teddy Book Data Extraction Form

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Valid date range for this visit : **28 Jun 2007** until **27 Sep 2007**.

Interview Date					Visit Location Code	
TEDDY Staff Code						

Visit 1189

6 months
 9 months
 12 months
 15 months
 18 months
 21 months
 24 months

Person(s) Interviewed 1190

Mother
 Father
 Other Primary Caretaker
 Other

Person(s) Interviewed Other Code 1191

Page: 1 of 14

Go to page:

1. Child's early Diet * 772

a. Does the child now get any breast milk - even in small amounts in combination with other foods?

No (fill in the date breast feeding stopped) ChildGetsBreastFeedOrNot
 Yes (Fill in the table)
 The baby was never breast fed

If the child gets breast milk mark the current age in months of the child:

Child's age in months 773 ChildAge

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Has the breast feeding stopped since the last TEDDY visit? If it has stopped when did it stop:

<input style="width:30px;" type="text" value="774"/>	<input style="width:30px;" type="text" value="775"/>	<input style="width:30px;" type="text" value="776"/>	BreastFeedStopDate	OR	at the age of: <input style="width:30px;" type="text" value="777"/>	BreastFeedStopAge
					<input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months	778 StopAgeDaysWeeksMonths

b. Is the child given any formula - even in small amounts?

No Yes 779 ChildGivenFormulaOrNot

Ready to feed, Powder, or Liquid concentrate?	Code	Started Formula(Age in months)	Stopped Formula(Age in months)	Why did they change formula brands/types?
<input type="radio"/> Ready to feed 814 InfantFormulaStartAge				WhyChangedBrandsTypes
<input type="radio"/> Powder PowderLiquid	<input style="width:30px;" type="text" value="815"/>	<input style="width:30px;" type="text" value="816"/>	<input style="width:30px;" type="text" value="817"/>	<input style="width:30px;" type="text" value="1963"/> <input style="width:30px;" type="text" value="1974"/>
<input type="radio"/> Liquid concentrate	LiquidPowderCode		InfantFormulaStopAge	ChangdFormulaBrandTypeCode2
<input type="radio"/> Ready to feed				
<input type="radio"/> Powder	<input style="width:30px;" type="text"/>	<input style="width:30px;" type="text"/>	<input style="width:30px;" type="text"/>	<input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/>
<input type="radio"/> Liquid concentrate				
<input type="radio"/> Ready to feed				
<input type="radio"/> Powder	<input style="width:30px;" type="text"/>	<input style="width:30px;" type="text"/>	<input style="width:30px;" type="text"/>	<input style="width:30px;" type="text"/> <input style="width:30px;" type="text"/>
<input type="radio"/> Liquid concentrate				

2. Introduction of New food Items - Since the last visit, has the child been given another new food item or something other than breast milk? *

 No

 Yes 1394

ChildGivenNewFoodSinceLastTime

	Food item	Age in months
1.	Apple sauce or apple juice applesaucejuice	780
2.	Fruit or berries (purees and juices- except apple sauce or apple juice) fruitberries	781
3.	Potatoes potatoes	782
4.	Sweet potatoes or yams sweetpotatoesyams	783
5.	Carrots carrots	784
6.	Spinach spinach	785
7.	Beets beets	786
8.	Peas / green beans PEASGREENBEANS	787
9.	Turnip/parsnip/artichoke/rutabaga/jerusalem turnipparsnipartichoke	788
10.	Cabbages (Chinese cabbage, red cabbage, cauliflower, broccoli, kale, cabbage turnip, collard, mustard or turnip greens) cabbages	789
11.	Squash/pumkin squashpumkin	790
12.	Tomato or tomato sauce tomatotomatosauce	791
13.	Corn (sweet corn and cereals, porridge, bread, tortillas, and biscuits made with corn flour) Corn	792
14.	Other vegetable othervegetable	793
15.	Rice (cereals, porridge, bread, teething biscuits, crackers, cookies, and pasta made with rice flour) Rice	794
16.	Wheat (cereals, porridge, bread, teething biscuits, crackers, tortillas, cookies, and pasta made with wheat flour) Wheat	795
17.	Barley (cereals, porridge, bread, teething biscuits, made with barley flour) barley	796
18.	Oat (cereals, porridge, bread, teething biscuits, made with oat flour) oat	797
19.	Rye (cereals, porridge, bread, teething biscuits, made with rye flour) Rye	798
20.	Buckwheat and millet (cereals, porridge, bread, tortillas, and teething biscuits made with this type of flour) buckwheatmillet	799
21.	Pork, beef porkbeef	800
22.	Poultry poultry	801
23.	Other kinds of meat (e.g. lamb, deer, reindeer) othermeat	802
24.	Sausage / hot dogs sausagehotdogs	803
25.	Fish and other seafood fishotherseafood	804
26.	Egg egg	805
27.	Milk products (cheese, sour cream, yogurt, cottage cheese), commercial baby foods containing yogurt or cottage cheese MilkProducts	806
28.	Regular cow's milk or ice cream (remember to include milk used in cooking) regularcowmilkicecream	807
29.	Commercial baby food containing milk or infant formula (e.g. children's ready made cereals, porridges, and porridge powders) commercialbabyfood	808
30.	Soy milk and other soy soy products SoyMilk	809
31.	Rice milk ricemilk	810
32.	Goat/Horse/Sheep milk goatmilk	811
33.	other otherfoodintro	813
	Code <input type="text" value="812"/> OtherFoodThanBreastMilkAgeCode	

Introduction of New Food Items continued				
Food item			Age in months	
34. Other Code	<input type="text" value="1192"/>	ChildNewFoodCode1	<input type="text" value="1193"/>	ChildNewFoodAge1
35. Other Code	<input type="text" value="1194"/>	ChildNewFoodCode2	<input type="text" value="1195"/>	ChildNewFoodAge2
36. Other Code	<input type="text" value="1196"/>	ChildNewFoodCode3	<input type="text" value="1197"/>	ChildNewFoodAge3
37. Other Code	<input type="text" value="1198"/>	ChildNewFoodCode4	<input type="text" value="1199"/>	ChildNewFoodAge4
38. Other Code	<input type="text" value="1200"/>	ChildNewFoodCode5	<input type="text" value="1201"/>	ChildNewFoodAge5
39. Other Code	<input type="text" value="1202"/>	ChildNewFoodCode6	<input type="text" value="1203"/>	ChildNewFoodAge6
40. Other Code	<input type="text" value="1204"/>	ChildNewFoodCode7	<input type="text" value="1205"/>	ChildNewFoodAge7
Other Codes		Age		
<input type="text" value="1923"/>	<input type="text" value="1924"/>	NewFoodOtherCode	NewFood_OtherAge	
<input type="text"/>	<input type="text"/>			
<input type="button" value="Add"/>				

3. other Diet Choices Is the child on any new diets?*

No Yes 1206 **IsChildOnNewDiets** GlutenfreeDietAgeStarted

GLUTENFREEDIETAGESTOPPED

	Type of Diet	Started (Months)	Stopped (Months)	Recommended by a health care provider?
a.	Cow's milk avoidance due to allergy in the child <small>CowsMilkAvoirdChildAgeDietStart</small>	819	820	<input type="radio"/> No <input type="radio"/> Yes <small>CowMilkAvoirdSuggestedByProvide</small>
b.	Cereal or wheat avoidance due to allergy in the child <small>CerealWheatAvoirdanceAgeStarted</small>	822	823	<input type="radio"/> No <input type="radio"/> Yes 824 <small>CerealWheatAvoirdanceAgeStopped</small>
c.	Gluten-free diet due to celiac disease in the child	825	826	<input type="radio"/> No <input type="radio"/> Yes 827 <small>GlutenfreeDietProvider</small>
d.	Vegetarian Diet What types of food does your child eat on this vegetarian diet? <input type="checkbox"/> Plant products <input type="checkbox"/> Milk and milk products <input type="checkbox"/> Eggs <input type="checkbox"/> Fish <small>TypeOfFoodChildHasVe_Eggs TypeOfFoodChildHasVe_Fish TypeOfFoodChildHasVe_Milkandmilk TypeOfFoodChildHasVe_Plantproduc</small>	828	829	<input type="radio"/> No <input type="radio"/> Yes 830 <small>VegetarianDietStartAge VegetarianDietStopAge VegeDietSuggestedByHealthCare</small>
e.	Kosher Diet	832	833	<input type="radio"/> No <input type="radio"/> Yes 834 <small>KosherDietSuggestedByHealthCare</small>
f.	Other Diet Code <input type="text" value="838"/>	837	835	<input type="radio"/> No <input type="radio"/> Yes 836 <small>OtherDietSuggestedByHealthCare</small>

Other codes	Started (Months)	Stopped (Months)	Recommended by a health care provider?
<input type="text" value="1935"/>	<input type="text" value="1936"/>	<input type="text" value="1937"/>	<input type="radio"/> No <input type="radio"/> Yes 1938
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes <small>OtherDietSuggestedByHealthC1_1</small>
<input type="button" value="Add"/>			

4. Allergies Does the child have any new allergies?*

No Yes 839

ChildHasNewAllergyOrNot

The child is allergic to:	Code	When did the allergy start? (Age in Months)	If the allergy has stopped, when did it stop (Age in months)?	What symptoms does the child have? Code	Recommended by a health care provider?
	ChildAllergicCode1 840	841 AgeAllergyStarted1	3804 AgeAllergyStopped1	842 ChildSymptomsCode1a 843 ChildSymptomsCode1b 844 ChildSymptomsCode1c	HealthCareProv1RecommendOrNot 845 <input type="radio"/> No <input type="radio"/> Yes
	846 ChildAllergicCode2	847 AgeAllergyStarted2	3805	848 849 850	851 <input type="radio"/> No <input type="radio"/> Yes HealthCareProv2RecommendOrNot

Code	When did the allergy start? (Age in Months)	If the allergy has stopped, when did it stop? (Age in months)	Allergy symptoms - Code	Recommended by a health care provider?
3103	3105	3808	3106 3107 3108	RecommendedByHealthCareProv1_1 <input type="radio"/> No <input type="radio"/> Yes 3109
				<input type="radio"/> No <input type="radio"/> Yes
				<input type="radio"/> No <input type="radio"/> Yes
				<input type="radio"/> No <input type="radio"/> Yes

5. Weight and Length or Height - Fill in weight and length or height every time the child is weighed and measured by a health care provider.

Date of measurement (DD / MMM / YYYY)	Weight			Length or Height	
	Pounds	Ounces	Kgs	Inches	Cms
852, 853, 854	855	856	1539	857	1545
858, 859, 860	861	862	1540	863	1546
864, 865, 866	867	868	1541	869	1547
870, 871, 872	873	874	1542	875	1548
876, 877, 878	879	880	1543	881	1549
882, 883, 884	885	886	1544	887	1550

Date of Measurement	Weight in Pounds	Weight in Ounces	Weight in Kgs	Height in Inches	Height in Cms
	2131	2132	2133	2134	2135

Add

WeightPoundsDynamic

WeightOuncesDynamic

WeightKgsDynamic

HeightInchesDynamic

HeightCmsDynamic

2128, 2129, 2130

6. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 888 **ChildGivenVaccineOrNot**

Was the child's vaccination card checked by the TEDDY staff member?

No Yes 3453 **ChildsVaccinationCardChecked**

Vaccination (For US and Germany)	Date of first vaccine (DD / MMM/ YYYY)	Date of second vaccine (DD / MMM/ YYYY)	Date of third vaccine (DD / MMM/ YYYY)
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	889 890 891	892 893 894	895 896 897
OR Diphtheria Tetanus (Td/DT)	898 899 900	901 902 903	904 905 906
Polio (OPV or IPV)	907 908 909	910 911 912	913 914 915
Haemophilus influenzae B (HiB)	916 917 918	919 920 921	922 923 924
Measles, Mumps, Rubella (MMR)	925 926 927	928 929 930	3488 3489 3490 (For Germany)
Hepatitis B (HB)	931 932 933	934 935 936	937 938 939
Varicella (Chicken Pox)	940 941 942	3119 3120 3121	
Tuberculosis* (BCG) *This may be given at birth	952 953 954	1879 1880 1881 (For Germany)	1882 1883 1884 (For Germany)
Other Code 973	955 956 957	958 959 960	961 962 963
Other Code 974	964 965 966	967 968 969	970 971 972
Other Code	Date of first vaccine	Date of second vaccine	Date of third vaccine
3449	3461 3462 3463	3464 3465 3466	3467 3468 3469

- DTP1STVACCDATEAGE
- DTP2NDVACCDATEAGE
- DTP3RDVACCDATEAGE
- DTP4THVACCDATEAGE
- DTP5THVACCDATEAGE
- TD1STVACCDATEAGE
- TD2NDVACCDATEAGE
- TD3RDVACCDATEAGE
- TD4THVACCDATEAGE
- TD5THVACCDATEAGE
- POLIO1STVACCDATEAGE
- POLIO2NDVACCDATEAGE
- POLIO3RDVACCDATEAGE
- POLIO4THVACCDATEAGE
- POLIO5THVACCINATIONDATEAGEFOR
- HIB1STVACCDATEAGE
- HIB2NDVACCDATEAGE
- HIB3RDVACCDATEAGE
- HIB4THVACCDATEAGE
- HIB5THVACCINATIONDATEAGEFORGE
- MEASLES1STVACCDATEAGE
- MEASLES2NDVACCDATEAGE
- MEASLESDATEOFTHIRDVACINEAGE
- HEPATITISB1STVACCDATEAGE
- HEPATITISB2NDVACCDATEAGE
- HEPATITISB3RDVACCDATEAGE
- HEPB5THVACCINATEDATEAGEFORGERMA
- HEPTITISBFOURTHDATEAGEFORGERM
- VARICELLA1STVACCDATEAGE
- VARICELLA2NDVACCINATIONDATEAGE
- TB1STVACCDATEAGE
- TBGERMANDATEAGE2

Vaccinations continued		
Vaccination	Date of fourth vaccine (DD / MMM/ YYYY)	Date of fifth vaccine (DD / MMM/ YYYY)
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	978 979 980	981 982 983
OR Diphtheria Tetanus (Td/DT)	984 985 986	987 988 989
Polio (OPV or IPV)	990 991 992	3122 3123 3124 (For Germany)
Haemophilus influenzae B (HiB)	993 994 995	3125 3126 3127 (For Germany)
Measles, Mumps, Rubella (MMR)		
Hepatitis B (HB)	2136 2137 2138	3128 3129 3130 (For Germany)
Varicella (Chicken Pox)		
Tuberculosis* (BCG) *This may be given at birth	1885 1886 1887 (For Germany)	
Other Code 1008	999 1000 1001	1002 1003 1004
Other Code 1009	1005 1006 1007	1207 1208 1209
Other Code	Date of fourth vaccine	Date of fifth vaccine
3450	3470 3471 3472	3473 3474 3475

6. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?* No Yes 888

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

 No Yes 3453

ChildsVaccinationCardChecked

ROKOTUS (For Finland)	1. rokotuksen päivämäärä (DD / MMM/ YYYY)	2. rokotuksen päivämäärän (DD / MMM/ YYYY)	3. rokotuksen päivämäärä (DD / MMM/ YYYY)
DTaP-IPV-Hib	1754 1755 1756	1757 1758 1759	1760 1761 1762
MPR	1769 1770 1771	1772 1773 1774	1775 1776 1777
Hepatiitti B	1817 1818 1819	1820 1821 1822	1823 1824 1825
Varicella	1826 1827 1828	1790 1791 1792	1793 1794 1795
BCG	1841 1842 1843	1805 1806 1807	1808 1809 1810
Muu	1874 1844 1845 1846	1847 1848 1849	1850 1851 1852
Muu	1877 1859 1860 1861	1862 1863 1864	1865 1866 1867
MUU	1. rokotuksen päivämäärä (DD / MMM/ YYYY)	2. rokotuksen päivämäärä (DD / MMM/ YYYY)	3. rokotuksen päivämäärä (DD / MMM/ YYYY)
4146	4151 4156 4161	4152 4157 4162	4153 4158 4163

ROKOTUS	4. rokotuksen päivämäärä (DD / MMM/ YYYY)	5. rokotuksen päivämäärän (DD / MMM/ YYYY)
DTaP-IPV-Hib	1763 1764 1765	1766 1767 1768
MPR	1778 1779 1780	1781 1782 1783
Hepatiitti B	1784 1785 1786	1787 1788 1789
Varicella	1796 1797 1798	1799 1800 1801
BCG	1811 1812 1813	1814 1815 1816
Muu	1875 1853 1854 1855	1856 1857 1858
Muu	1878 1868 1869 1870	1871 1872 1873
MUU	4. rokotuksen päivämäärä (DD / MMM/ YYYY)	5. rokotuksen päivämäärä (DD / MMM/ YYYY)
4149	4154 4159 4164	4155 4160 4165

6. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?* No Yes

888

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

 No Yes

3453

ChildsVaccinationCardChecked

Vaccination (For Sweden)	1:a vaccinationen (DD / MMM / YYYY)			2:a vaccinationen (DD / MMM / YYYY)			3:e vaccinationen (DD / MMM / YYYY)		
Difteri	1551	1552	1553	1554	1555	1556	1557	1558	1559
Stelkramp	1560	1561	1562	1563	1564	1565	1566	1567	1568
Kikhosta	1570	1571	1572	1573	1574	1575	1576	1577	1578
Polio	1579	1580	1581	1582	1583	1584	1585	1586	1587
Haemofilus influense B	1588	1589	1590	1591	1592	1593	1594	1595	1596

Tuberkulos	1597	1598	1599	
Massling	1600	1601	1602	
Passjuka	1603	1604	1605	
Roda hund	1606	1607	1608	
Vattkoppor	1609	1610	1611	
Rotavirus	1612	1613	1614	
Hepatit B	1615	1616	1617	
Annan, vad? Kod	1618	1619	1620	1621
Annan, vad? Kod	1622	1623	1624	1625

8a. Acute Illnesses - Has the child been ill since the last visit? Record all chronic illnesses/conditions on the next page.

No Yes 1026

ChildIllSinceLastVisit

Date Illness first appeared	ICD-10 Code: ONLY code <u>Symptoms</u> here (ALWAYS CODE SYMPTOMS)	Fever? (temperature is equal to or higher than 38°C or 101°F) or Diagnosis: ICD-10 Code
-----------------------------	--	--

1027	1028	1029	1030	1031	1032	<input type="checkbox"/> No Symptoms	2726	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	2728	IllnessDiagnosisCode <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider 2727	
DATEILLNESSAPPEAREDAGE10_1						Illness symptom code1 Illness symptom code2 Illness symptom code3		IllnessFever	IllnessDiagnosis		
						<input type="checkbox"/> No Symptoms					
						<input type="checkbox"/> No Symptoms					
						<input type="checkbox"/> No Symptoms					
						<input type="checkbox"/> No Symptoms					
						<input type="checkbox"/> No Symptoms					

Add

8b. Chronic Illnesses - Since the last visit, has your child been diagnosed by a health care provider with any chronic illness or condition?

A chronic illness is a condition generally lasting 3 months or longer. It is permanent, long lasting or results in residual disability. A chronic disease can also be recurrent and relapse repeatedly with periods of remission.

No
 Yes 3738
 ChildDiagnosedChronicIllnes

Chronic illness/condition diagnosed by health care provider: ICD-10 Code	Date of diagnosis of chronic illness/condition by health care provider(MMM/YYYY)	Date chronic illness went into remission(MMM/YYYY)																								
<table border="1" style="width: 100%;"> <tr><td style="width: 50%;">3750</td><td style="width: 50%;"></td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	3750								<table border="1" style="width: 100%;"> <tr><td style="width: 50%;">3739</td><td style="width: 50%;">3740</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	3739	3740							<table border="1" style="width: 100%;"> <tr><td style="width: 50%;">3741</td><td style="width: 50%;">3742</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	3741	3742						
3750																										
3739	3740																									
3741	3742																									
ChronicIllnessICD10Code1_1	AGEDIAGNOSISCHRONICILLNESS1_1	AGECHRONICILLNESSREMISSION1_1																								
<input type="button" value="Add"/>																										

9. Medications

Has the child been given any medications - any kind of prescription medication (oral, topical, injection, etc.) and/or oral "over the counter" medication, since the last visit? NOTE: Do not include vitamins and other dietary supplements here.

No Yes

1035

MedicationGivenToChildOrNot

Name of Medication	Name of Medication: Code	Reason for Medication: Code	How old was your child when they received this medication? (Age in months)	For how many days did you give the medication?
MedicationName10_1	MedicationCode10_1	MedNonTreatmentReason10_1	ChildAgeWhenGotMedication10_1	NumDaysMedication10_1
1939	1036	1037 <input type="checkbox"/> Non-treatment reason 3110	1038	1039 <input type="checkbox"/> Ongoing 2164 <input type="checkbox"/> As needed 1040
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason 3117 for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
		<input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above		<input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
Add	MedicationReasonCode10_1	AddReasonForMedAbove10_1	MedicationOngoingOrNot10_1	MedicationAsNeeded10_1

10. Hospitalizations of the child
Has the child been in the hospital since the last visit? ChildInHospitalSinceLastVisit

No Yes 1041

Date (DD/ MMM/ YYYY)	# of nights hospitalized	Reason for hospitalization	Do we have signed medical records authorization to view hospital charts?
<input type="text" value="1042"/> / <input type="text" value="1043"/> / <input type="text" value="1044"/> DATEAGE	<input type="text" value="1045"/> NumNightsHospitalized <input type="checkbox"/> ER visit Only 1046 <input type="checkbox"/> Outpatient treatment 2209 OutpatientTreatment	Code <input type="text" value="1047"/> ReasonHospitalizedCode	1048 <input type="radio"/> No <input type="radio"/> Yes HaveRightsToViewMedCharts
<input type="text" value="1049"/> / <input type="text" value="1050"/> / <input type="text" value="1051"/> DATEAGE	<input type="text" value="1052"/> NumNightsHospitalized2 ERVisitOnly <input type="checkbox"/> ER visit Only 1053 <input type="checkbox"/> Outpatient treatment 2210 OutpatientTreatment2	Code <input type="text" value="1054"/> ReasonHospitalization	1055 <input type="radio"/> No <input type="radio"/> Yes HaveRightsToViewMedCharts2
<input type="text" value="1056"/> / <input type="text" value="1057"/> / <input type="text" value="1058"/> DATEAGE	<input type="text" value="1059"/> NumNightsHospitalized3 ERVisitOnly3 <input type="checkbox"/> ER visit Only 1060 <input type="checkbox"/> Outpatient treatment 2211 OutpatientTreatment3	Code <input type="text" value="1061"/> ReasonHospitalization3	1062 <input type="radio"/> No <input type="radio"/> Yes HaveRightsToViewMedCharts3

Date	No. of nights hospitalized	Reason for hospitalization Code	Do we have signed medical records authorization to view hospital charts?
<input type="text" value="2157"/> <input type="text" value="2158"/> <input type="text" value="2159"/>	<input type="text" value="2160"/> <input type="checkbox"/> ER visit only <input type="checkbox"/> Outpatient treatment 2212 HospitalizationsERVisitOnly10_1	<input type="text" value="2162"/> ReasonForHospitalizationCod10_1	<input type="radio"/> No <input type="radio"/> Yes AuthorizedToViewHospitalCha10_1
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="checkbox"/> ER visit only <input type="checkbox"/> Outpatient treatment HospitalizationOutpatientTr10_1	<input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes
<input type="button" value="Add"/>			

11. Day care or Other Social Groups

We are interested in keeping track of those times that your child is regularly (once a week or more) around other children. This could be day care or other regular social get-togethers. Below is a place to record day care situations and the next page is for other social groups.

Day Care: Is the child at the present time in a new day care situation that includes at least 1 other child, who is not a sibling, or has anything changed in the day care situation since the last visit (change of day care facility, number of children in group, # of hours attended)?

ChildInDayCareOrNot

No Yes 1063

Don't forget to record the end date for any day care situations that may have stopped!

Date Started (MMM/YYYY) DAYCARESTARTDATEAGE		Until (MMM/YYYY) DAYCAREUNTILAGE1		Type of day care TypeOfDaycare1	Type of day care: Code DayCareTypeCode1	Hours per week attended AttendedHrsPerWeek1	Total # of children in child's group/class
1064	1065	1066	1067	3703	1068	1069	1070
1071	1072	1073	1074	3704	1075	1076	1077
1078	1079	1080	1081	3705	1082	1083	1084

NumChildrenChildGroup

Date Started(MMM/YYYY)		Until(MMM/YYYY)		Type of day care	Type of day care:Code	Hours per week attended	Total # of children in child's group/class
2195	2196	2197	2198	3706	2199	2200	2201
Add				TypeOfDaycare1_1	DayCareHoursPerWeekAttended1_1		DayCareTotalNumOfchildrenIn1_1

DayCareTotalNumOfchildrenIn1_1

Day Care or Other Social Groups continued

Social Groups: Does the child regularly (atleast once a week) participate in a new group activity with other children, who are not the child's siblings? Do not include day care. This could be a regular play group at your house or others, gymboeree, swimming class, etc.

No

Yes 1085

ChildsParticipationSocialGroup

SocialAttendHrsPerWeek1

Date Started (MMM/YYYY) SOCIALSTARTDATEAGE1		Until (MMM/YYYY) SOCIALUNTILAGE1		Type of social group TypeOfSocialGroup1	Type of social group: Code SocialGroupTypeCode1	Hours per week attended	Total # of children in child's group SocialNumChildGroup1
1086	1087	1088	1089	1090	3707	1091	1092
1093	1094	1095	1096	1097	3708	1098	1099
1100	1101	1102	1103	1104	3709	1105	1106
1107	1108	1109	1110	1111	3710	1112	1113

Date Started (MMM/YYYY)	Until(MMM/YYYY)	Type of social group	Type of social group:Code	Hours per week attended	Total # of children in child's group
2202	2204	2206	3711	2207	2208
2203	2205				
Add					

12a. Parent Life events - Here is a list of a number of life experiences people sometimes have. Did you have any of these experiences since we saw you last?
 No Yes 1114 **ParentLifeEvents**

12b. Child Life Experiences - Here is a list of experiences that may have happened to your child. Has your child had any of these experiences since we saw you last?
 No Yes 1115 **ChildLifeExpsYesNo**

Event number	List the age of child (in months) when the event occurred	Impact on you ? IMPACTONYOU	Impact on the child ? IMPACTONCHILD	Continuous Life Event?
1116	1117	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1118	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1119	<input type="checkbox"/> Yes 1964
1120	1121	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1122	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1123	<input type="checkbox"/> Yes 1968
1124	1125	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1126	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1127	<input type="checkbox"/> Yes 1969
1128	1129	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1130	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1131	<input type="checkbox"/> Yes 1970
1132	1134	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1136	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1138	<input type="checkbox"/> Yes 1971
1133	1135	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1137	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 1139	<input type="checkbox"/> Yes 1972

Event Number	Age in Months	Impact On You	Impact On Child	Continuous Life Event?
2086	2087	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 2088	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 2089	<input type="checkbox"/> 2090
		<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="checkbox"/>

ChildLifeExperiencesAgeInMonths
ChildLifeExperiencesImpactOnChild
ChildLifeExperiencesContinuousLifeEvent

Specify other events: 21.	1140	Codes must begin with PE for parent events	OtherEventsCode1
22.	1141	Codes must begin with PE for parent events	OtherEventsCode2
34.	3906	Codes must begin with PE for parent events	PARENTLIFEOTHEREVENTSCODE3
35.	3907	Codes must begin with PE for parent events	PARENTLIFEOTHEREVENTSCODE4
36.	3908	Codes must begin with PE for parent events	PARENTLIFEOTHEREVENTSCODE5
37.	3909	Codes must begin with PE for parent events	PARENTLIFEOTHEREVENTSCODE5
38.	3910	Codes must begin with PE for parent events	PARENTLIFEOTHEREVENTSCODE6
32.	1142	Codes must begin with CE for child events	OtherEventsCode3
33.	1143	Codes must begin with CE for child events	OtherEventsCode4
39.	3911	Codes must begin with CE for child events	CHIDLIFEOTHEREVENTSCODE3
40.	3912	Codes must begin with CE for child events	CHIDLIFEOTHEREVENTSCODE4
41.	3913	Codes must begin with CE for child events	CHIDLIFEOTHEREVENTSCODE5
42.	3914	Codes must begin with CE for child events	CHIDLIFEOTHEREVENTSCODE6
43.	3915	Codes must begin with CE for child events	CHIDLIFEOTHEREVENTSCODE7

English Teleform

Swedish Teleform

German Teleform

Finnish Teleform

Spanish Teleform

TEDDY**The Environmental Determinants of Diabetes in the Young****Teddy Book for 2-5 year olds
Data Extraction Form**

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Valid date range for this visit : **28 Mar 2010** until **27 Jun 2010**.

Interview Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	* Visit Location Code	<input type="text"/>	*
----------------	----------------------	----------------------	----------------------	-----------------------	----------------------	---

TEDDY Staff Code	<input type="text"/>	*
------------------	----------------------	---

Visit	2264					
<input type="radio"/>	27 months	<input type="radio"/>	30 months	<input checked="" type="radio"/>	33 months	VisitNum
<input type="radio"/>	36 months	<input type="radio"/>	39 months	<input type="radio"/>	42 months	
<input type="radio"/>	45 months	<input type="radio"/>	48 months	<input type="radio"/>	51 months	
<input type="radio"/>	54 months	<input type="radio"/>	57 months	<input type="radio"/>	60 months	
<input type="radio"/>	63 months	<input type="radio"/>	66 months	<input type="radio"/>	69 months	
<input type="radio"/>	72 months					

Persons(s) Interviewed	2272	
<input type="checkbox"/>	Father	<input type="checkbox"/>
<input type="checkbox"/>	Mother	<input type="checkbox"/>
<input type="checkbox"/>	Other Primary Caretaker	<input type="checkbox"/>
<input type="checkbox"/>	Other	
Persons(s) Interviewed Other Code	<input type="text" value="2273"/>	OtherPersonInterviewedCode

1. Child's Early Diet * 2265 ChildGetsBreastFeedOrNot

Does the child now get any breast milk?

No (fill in the date breast feeding stopped)

Yes (Fill in the table)

The baby was never breast fed

If the child gets breast milk mark the current age in months of the child:

Child's age in months 2269 ChildsAgeInMonths

25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42
 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Has the breast feeding stopped since the last TEDDY visit? If it has stopped when did it stop:

OR at the age of: AgeYears years months BREASTFEEDSTOPDATEAGE

BREASTFEEDSTOPDATE1

2. Allergies : * Does the child have any new allergies? No Yes 2274 ChildHasNewAllergyOrNot

The child is allergic to:	Code	When did the allergy start? (Age in years and months)	If the allergy has stopped, when did it stop (Age in years and months)?	Code	Recommended by a health care provider?	If health care provider told caretaker child has allergy, how was it diagnosed?
---------------------------	------	---	---	------	--	---

CHILDALLERGY1_1 DATE ALLERGY STOPPED

years years AllergyCode1_1 2738
 months months No DiagnosisType1_1 2287
 Yes

DATE ALLERGY STOPPED

HEALTHCAREPROV1RECOMMENDORNOT

Skin test

Blood test

Challenge test

Other clinical test

No clinical test was done

Do not know whether test was done

ChildAllergy2_1

years years
 months months No
 Yes

Skin test

Blood test

Challenge test

Other clinical test

No clinical test was done

Do not know whether test was done

ChildAllergy3_1

years years
 months months No
 Yes

Skin test

Blood test

Challenge test

Other clinical test

No clinical test was done

Do not know whether test was done

3. All Special Diets: Is the child on any new diets?*

No Yes 2337

IsChildOnNewDiets

AVOIDANCECOWSMILKSTARTEDMON
AVOIDANCECOWSMILKSTARTEDYRS

AVOIDANCECOWSMILKSTOPPEDMON
AVOIDANCECOWSMILKSTOPPEDYRS

Type of Diet	Started (years and months)	Stopped (years and months)	Recommended by a health care provider?
a. Avoidance of cow's milk and milk products due to allergy in the child	2316 years 2317 months <small>Age Cereal or Wheat Avoidance Started</small>	2318 years 2319 months <small>Age Cereal or Wheat Avoidance Stopped</small>	<input type="radio"/> No <input type="radio"/> Yes 2310 <small>CowMilkAvoidSuggestedByProvide</small>
b. Cereal or wheat avoidance due to allergy in the child	2320 years 2321 months	2322 years 2323 months	<input type="radio"/> No <input type="radio"/> Yes 2314 <small>CerealAvoidSuggestedByProvider</small>
c. Gluten-free diet due to celiac disease in the child	2324 years 2325 months	2326 years 2327 months	<input type="radio"/> No <input type="radio"/> Yes 2312 <small>GlutenfreeDietProvider</small>
d. Vegetarian Diet What types of food does the child eat on this vegetarian diet? (Mark all that apply)	2328 years 2329 months	2330 years 2331 months	<input type="radio"/> No <input type="radio"/> Yes 2313 <small>VegeDietSuggestedByHealthCare</small>
<input type="checkbox"/> Plant products <small>TypeOfFoodChildHasVe_Plantproduc</small> <input type="checkbox"/> Milk and milk products <small>TypeOfFoodChildHasVe_Milkandmilk</small> <input type="checkbox"/> Eggs <small>TypeOfFoodChildHasVe_Eggs</small> <input type="checkbox"/> Fish <small>TypeOfFoodChildHasVe_Fish</small>			
e. Other Diet			

Other Diet (Specify and Code)	Started (years and months)	Stopped (years and months)	Recommended by a health care provider?
2748 2750	2744 years 2745 months	2746 years 2747 months	<input type="radio"/> No <input type="radio"/> Yes 2749
<input type="button" value="Add"/>	<small>OtherDietSpecify1_1</small>	<small>OtherDietCode1_1</small>	<small>Age Other Diet Started</small>
	<small>Age Other Diet Stopped</small>	<small>OtherDietRecommendedbyprovi1_1</small>	

OTHERDIETSTARTEDMON1
OTHERDIETSTARTEDYRS1

OTHERDIETSTOPPEDMON1
OTHERDIETSTOPPEDYRS1

5. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 2491

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

No Yes 3454

ChildsVaccinationCardChecked

Vaccination (For US and Germany)	Date of first vaccine (DD / MMM / YYYY)	Date of second vaccine (DD / MMM / YYYY)	Date of third vaccine (DD / MMM / YYYY)
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	2346 2347 2348	2349 2350 2351	2352 2353 2354
OR Diphtheria Tetanus (Td/DT)	2355 2356 2357	2358 2359 2360	2361 2362 2363
Polio (OPV or IPV)	2364 2365 2366	2367 2368 2369	2370 2371 2345
Haemophilus influenzae B (HiB)	2372 2373 2374	2375 2376 2377	2378 2379 2380
Measles, Mumps, Rubella (MMR)	2381 2382 2383	2384 2385 2386	3492 3493 3491 (For Germany)
Hepatitis A	2473 2474 2475	2476 2477 2478	2479 2480 2481
Hepatitis B (HB)	2487 2388 2489	2490 2391 2492	2493 2394 2494
Hepatitis A&B (combination)	2482 2483 2484	2485 2486 2487	2488 2489 2490
Varicella (Chicken Pox)	2396 2397 2398	3260 3261 3262	
Tuberculosis* (BCG) *this may have been given at birth	2408 2409 2410		
Influenza (For injectable influenza vaccine only; code V0037 should be used to indicate nasal influenza vaccine)	2431 2432 2433	2434 2435 2436	2437 2438 2439
Rotavirus	2440 2441 2442	2443 2444 2445	2446 2447 2448
Other Code 2429	2411 2412 2413	2414 2415 2416	2417 2418 2419
Other Code 2430	2420 2421 2422	2433 2424 2425	2426 2427 2428
Other Code 2462	2449 2450 2451	2452 2453 2454	2455 2456 2457
Other Code 2472	2463 2464 2465	2466 2467 2468	2469 2470 2471

Other Code Date of first vaccine Date of second vaccine Date of third vaccine

3511 3497 3498 3499 3500 3501 3502 3503 3504 3505

Add

DTP1STVACCDATEAGE
DTP2NDVACCDATEAGE
DTP3RDVACCDATEAGE
DTP4THVACCDATEAGE
DTP5THVACCDATEAGE
TD1STVACCDATEAGE
TD2NDVACCDATEAGE
TD3RDVACCDATEAGE
TD4THVACCDATEAGE
TD5THVACCDATEAGE
POLIO1STVACCDATEAGE
POLIO2NDVACCDATEAGE
POLIO3RDVACCDATEAGE
POLIO4THVACCDATEAGE
POLIO5THVACCINATIONDATEAGEFOR
HIB1STVACCDATEAGE
HIB2NDVACCDATEAGE
HIB3RDVACCDATEAGE
HIB4THVACCDATEAGE
HIB5THVACCINATIONDATEAGEFORGE

MEASLES1STVACCDATEAGE
MEASLES2NDVACCDATEAGE
MEASLESDATEOFTHIRDVACCINEAGE
HEPATITISA1STVACCAGE
HEPATITISA2VACCAGE
HEPATITISA3VACCAGE
HEPATITISA4VACCAGE
HEPATITISA5VACCAGE
HEPATITISB1STVACCDATEAGE
HEPATITISB2NDVACCDATEAGE
HEPATITISB3RDVACCDATEAGE
HEPB5THVACCINATEDATEAGEFORGERMA
HEPATITISAANDB1VACCAGE
HEPATITISAANDB2VACCAGE
HEPATITISAANDB3VACCAGE
HEPATITISAANDB4VACCAGE
HEPATITISAANDB5VACCAGE
VARICELLA1STVACCDATEAGE
VARICELLA2NDVACCINATIONDATEAGE
VARICELLA3RDVACCDATEDAY

VARICELLA3RDVACCDATEYEAR
VARICELLADATEOF2NDVACCINATEDAYFO
INFLUENZA1VACCAGE
INFLUENZA2VACCAGE
INFLUENZA3VACCAGE
INFLUENZA4VACCAGE
INFLUENZA5VACCAGE
ROTAVIRUS1VACCAGE
ROTAVIRUS2VACCAGE
ROTAVIRUS3VACCAGE
ROTAVIRUS4VACCAGE
ROTAVIRUS5VACCAGE
OTHERDYNVACCINATIONCODE11_1
OTHERDYNVACCINATIONCODE12_1
OTHERDYNVACCINATIONCODE13_1
OTHERDYNVACCINATIONCODE41_1
OTHERDYNVACCINATIONCODE42_1

Vaccinations continued						
Vaccination	Date of fourth vaccine (DD / MMM/ YYYY)			Date of fifth vaccine (DD / MMM/ YYYY)		
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	<input type="text" value="2494"/>	<input type="text" value="2495"/>	<input type="text" value="2496"/>	<input type="text" value="2497"/>	<input type="text" value="2498"/>	<input type="text" value="2499"/>
OR Diphtheria Tetanus (Td/DT)	<input type="text" value="2500"/>	<input type="text" value="2501"/>	<input type="text" value="2502"/>	<input type="text" value="2503"/>	<input type="text" value="2493"/>	<input type="text" value="2492"/>
Polio (OPV or IPV)	<input type="text" value="2507"/>	<input type="text" value="2508"/>	<input type="text" value="2509"/>	<input type="text" value="3263"/>	<input type="text" value="3264"/>	<input type="text" value="3265"/> (For Germany)
Haemophilus influenzae B (HiB)	<input type="text" value="2510"/>	<input type="text" value="2511"/>	<input type="text" value="2512"/>	<input type="text" value="3266"/>	<input type="text" value="3267"/>	<input type="text" value="3268"/> (For Germany)
Measles, Mumps, Rubella (MMR)						
Hepatitis A	<input type="text" value="2527"/>	<input type="text" value="2528"/>	<input type="text" value="2529"/>	<input type="text" value="2530"/>	<input type="text" value="2531"/>	<input type="text" value="2532"/>
Hepatitis B (HB)	<input type="text" value="3269"/>	<input type="text" value="3270"/>	<input type="text" value="3271"/>	<input type="text" value="3272"/>	<input type="text" value="3273"/>	<input type="text" value="3274"/> (For Germany)
Hepatitis A & B (combination)	<input type="text" value="2533"/>	<input type="text" value="2534"/>	<input type="text" value="2535"/>	<input type="text" value="2536"/>	<input type="text" value="2537"/>	<input type="text" value="2538"/>
Varicella (Chicken Pox)						
Tuberculosis* (BCG) *This may be given at birth						
Influenza (For injectable influenza vaccine only; code V0037 should be used to indicate nasal influenza vaccine)	<input type="text" value="2539"/>	<input type="text" value="2540"/>	<input type="text" value="2541"/>	<input type="text" value="2542"/>	<input type="text" value="2543"/>	<input type="text" value="2544"/>
Rotavirus	<input type="text" value="2545"/>	<input type="text" value="2546"/>	<input type="text" value="2547"/>	<input type="text" value="2548"/>	<input type="text" value="2549"/>	<input type="text" value="2550"/>
Other	<input type="text" value="2516"/>	<input type="text" value="2517"/>	<input type="text" value="2518"/>	<input type="text" value="2519"/>	<input type="text" value="2520"/>	<input type="text" value="2521"/>
Code <input type="text" value="2525"/>						
Other	<input type="text" value="2522"/>	<input type="text" value="2523"/>	<input type="text" value="2524"/>	<input type="text" value="2504"/>	<input type="text" value="2505"/>	<input type="text" value="2506"/>
Code <input type="text" value="2526"/>						
Other	<input type="text" value="2551"/>	<input type="text" value="2552"/>	<input type="text" value="2553"/>	<input type="text" value="2554"/>	<input type="text" value="2555"/>	<input type="text" value="2556"/>
Code <input type="text" value="2557"/>						
Other	<input type="text" value="2558"/>	<input type="text" value="2559"/>	<input type="text" value="2560"/>	<input type="text" value="2561"/>	<input type="text" value="2562"/>	<input type="text" value="2563"/>
Code <input type="text" value="2564"/>						
Other Code	Date of fourth vaccine			Date of fifth vaccine		
<input type="text" value="3512"/>	<input type="text" value="3513"/>	<input type="text" value="3506"/>	<input type="text" value="3507"/>	<input type="text" value="3508"/>	<input type="text" value="3509"/>	<input type="text" value="3510"/>
<input type="text" value="Add"/>						

5. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 2491

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

No Yes 3454

ChildsVacinatonCardChecked

ROKOTUS (For Finland)	1. rokotuksen päivämäärä (DD / MMM / YYYY)			2. rokotuksen päivämäärän (DD / MMM / YYYY)			3. rokotuksen päivämäärä (DD / MMM / YYYY)			
Tuberkuloosi	2766	2767	2768	2769	2770	2771	2772	2773	2774	DTAPIPVHIBFINDATEAGE1 DTAPIPVHIBFINDATEAGE2 DTAPIPVHIBFINDATEAGE3 DTAPIPVHIBFINDATEAGE4 DTAPIPVHIBFINDATEAGE5 MPRFINLANDDATE1AGE
DTaP-IPV-Hib	2781	2782	2783	2784	2785	2786	2787	2788	2789	MPRFINLANDDATE2AGE MPRFINLANDDATE3AGE MPRFINLANDDATE4AGE MPRFINLANDDATE5AGE
MPR	2796	2797	2798	2799	2800	2801	2802	2803	2804	ROTAVIRUSFINLANDDATE1AGE ROTAVIRUSFINLANDDATE2AGE ROTAVIRUSFINLANDDATE3AGE ROTAVIRUSFINLANDDATE4AGE ROTAVIRUSFINLANDDATE5AGE
DTaP-IPV	2873	2874	2875	2876	2877	2878	2879	2880	2881	HEPATIITIAFINLANDDATE1AGE HEPATIITIAFINLANDDATE2AGE HEPATIITIAFINLANDDATE3AGE HEPATIITIAFINLANDDATE4AGE HEPATIITIAFINLANDDATE5AGE
Rotavirus	2888	2889	2890	2891	2892	2893	2894	2895	2896	HEPATIITIBFINLANDDATE1AGE HEPATIITIBFINLANDDATE2AGE HEPATIITIBFINLANDDATE3AGE HEPATIITIBFINLANDDATE4AGE HEPATIITIBFINLANDDATE5AGE
Hepatiitti A (HAV)	2903	2904	2905	2906	2907	0908	2909	2910	2911	TBEFINLANDDATE1AGE TBEFINLANDDATE2AGE TBEFINLANDDATE3AGE TBEFINLANDDATE4AGE TBEFINLANDDATE5AGE
Hepatiitti B (HBV)	2751	2752	2753	2754	2755	2756	2757	2758	2759	HEPATITISABFINLANDDATE1AGE HEPATITISABFINLANDDATE2AGE HEPATITISABFINLANDDATE3AGE HEPATITISABFINLANDDATE4AGE HEPATITISABFINLANDDATE5AGE
Hepatiitti A ja hepatiitti B	2918	2919	2920	2921	2922	2923	2924	2925	2926	INFLUENZAFINLAND1AGE INFLUENZAFINLAND2AGE INFLUENZAFINLAND3AGE INFLUENZAFINLAND4AGE INFLUENZAFINLAND5AGE
(TBE)	2933	2934	2935	2936	2937	2938	2939	2040	2941	
Influenssa (käytetään, kun influenssarokote on annettu pistoksena; koodia V0037 käytetään, kun influenssarokote on annettu nenän kautta)	2948	2949	2950	2951	2952	2953	2954	2955	2956	
Vesirokko	2826	2827	2828	2829	2830	2831	2832	2833	2834	
Muu 2871	2841	2842	2843	2844	2845	2846	2847	2848	2849	
Muu 2872	2856	2857	2858	2859	2860	2861	2862	2863	2864	
Muu 2978	2963	2964	2965	2966	2967	2968	2969	2970	2971	

ROKOTUS (For Finland)	4. rokotuksen päivämäärä (DD / MMM / YYYY)			5. rokotuksen päivämäärän (DD / MMM / YYYY)			
Tuberkuloosi	2775	2776	2777	2778	2779	2780	VARICELLAFINDATE1AGE VARICELLAFINDATE2AGE VARICELLAFINDATE3AGE VARICELLAFINDATE4AGE VARICELLAFINDATE5AGE
DTaP-IPV-Hib	2790	2791	2792	2793	2794	2795	TBEFINLANDDATE1AGE TBEFINLANDDATE2AGE TBEFINLANDDATE3AGE TBEFINLANDDATE4AGE TBEFINLANDDATE5AGE
MPR	2805	2806	2807	2808	2809	2810	BCGFINLANDDATE1AGE BCGFINLANDDATE2AGE BCGFINLANDDATE3AGE BCGFINLANDDATE4AGE BCGFINLANDDATE5AGE
DTaP-IPV	2882	2883	2884	2885	2886	2887	OTHER1FINLANDDATE1AGE OTHER1FINLANDDATE2AGE OTHER1FINLANDDATE3AGE OTHER1FINLANDDATE4AGE OTHER1FINLANDDATE5AGE
Rotavirus	2897	2898	2899	2900	2901	2902	
Hepatiitti A (HAV)	2912	2913	2914	2915	2916	2917	
Hepatiitti B (HBV)	2760	2761	2762	2763	2764	2765	
Hepatiitti A ja hepatiitti B	2927	2928	2929	2930	2931	2932	
(TBE)	2942	2943	2944	2945	2946	2947	
Influenssa (käytetään, kun influenssarokote on annettu pistoksena; koodia V0037 käytetään, kun influenssarokote on annettu nenän kautta)	2957	2958	2958	2960	2961	2962	
Vesirokko	2835	2836	2837	2838	2839	2840	
Muu 3098	2850	2851	2852	2853	2854	2855	
Muu 3099	2865	2866	2867	2868	2869	2870	
Muu 3100	2972	2973	2974	2975	2976	2977	

5. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 2491

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

No Yes 3454

ChildsVaccinationCardChecked

Vaccination(For Sweden)	1:a vaccinationen (DD / MMM/ YYYY)			2:a vaccinationen (DD / MMM/ YYYY)			3:e vaccinationen (DD / MMM/ YYYY)			4:e vaccinationen (DD / MMM/ YYYY)			
Tuberkulos (BCG)	2979	2980	2981	2982	2983	2984	2985	2986	2987				
MPR (mässling, påssjuka, röda hund)	2988	2989	2990	2991	2992	2993	2994	2995	2996				
Vattkoppor	2997	2998	2999	3000	3001	3002	3003	3004	3005				
Polio	3006	3007	3008	3009	3010	3011	3012	3013	3014	4104	4105	4103	
Rotavirus	3015	3016	3017	3018	3019	3020	3021	3022	3023				
Hepatit A (endast)	3024	3025	3026	3027	3028	3029	3030	3031	3032				
Hepatit B	3033	3034	3035	3036	3037	3038	3039	3040	3041				
Hepatit A & B (kombination)	3042	3043	3044	3045	3046	3047	3048	3049	3050				
Influensa (Endast för influensa vaccin som injiceras; kod V0037 ska användas för influensa vaccin som inhaleras)	3051	3052	3053	3054	3055	3056	3057	3058	3059				
TBE	3060	3061	3062	3063	3064	3065	3066	3067	3068				
Annan, vad? Kod	3087	3078	3079	3080	3081	3082	3083	3084	3085	3086	4106	4107	4108
Annan, vad? Kod	3097	3088	3089	3090	3091	3092	3093	3094	3095	3096	4109	4110	4111

TUBERCULOSISSWEDENDATE1AGE

TUBERCULOSISSWEDENDATE2AGE

TUBERCULOSISSWEDENDATE3AGE

MPRSWEDENDATE1AGE

MPRSWEDENDATE2AGE

MPRSWEDENDATE3AGE

VARICELLASWEDENDATE1AGE

VARICELLASWEDENDATE2AGE

VARICELLASWEDENDATE3AGE

POLIOSWEDENDATE1AGE

POLIOSWEDENDATE2AGE

POLIOSWEDENDATE3AGE

POLIOSWEDENDATE4AGE

ROTAVIRUSSWEDENDATE1AGE

ROTAVIRUSSWEDENDATE2AGE

ROTAVIRUSSWEDENDATE3AGE

HEPATITISASWEDENDATE1AGE

HEPATITISASWEDENDATE2AGE

HEPATITISASWEDENDATE3AGE

HEPATITISBSWEDENDATE1AGE

HEPATITISBSWEDENDATE2AGE

HEPATITISBSWEDENDATE3AGE

HEPATITISABSWEDEN1AGE

HEPATITISABSWEDEN2AGE

HEPATITISABSWEDEN3AGE

INFLUENZASWEDEN1AGE

INFLUENZASWEDEN2AGE

INFLUENZASWEDEN3AGE

TBESWEDENDATE1AGE

TBESWEDENDATE2AGE

TBESWEDENDATE3AGE

OTHER1SWEDENDATE1AGE

OTHER1SWEDENDATE2AGE

OTHER1SWEDENDATE3AGE

OTHER1SWEDENDATE4AGE

OTHER2SWEDENDATE1AGE

OTHER2SWEDENDATE2AGE

OTHER2SWEDENDATE3AGE

OTHER2SWEDENDATE4AGE

OTHERDYNWEVACCINATIONCODE1_1

OTHERDYNWEVACCINATIONCODE2_1

6. Dietary Supplements - Has the child been given any new single vitamins, multivitamins, or other dietary supplements (such as fish oils, antioxidants, or others) since the last visit?

No Yes 2574 DIETARYSUPP

Type of preparation and Brand Name:Code	drop(s)	milliliter(s)	tablet(s)	Other	Other Code	How many times a week?	Started (Age in years and months)		Stopped (Age in years and months)	
<input type="text" value="2575"/>	<input type="text" value="2576"/>	<input type="text" value="2570"/>	<input type="text" value="2571"/>	<input type="text" value="2572"/>	<input type="text" value="2573"/>	<input type="text" value="2577"/>	<input type="text" value="2578"/> years	<input type="text" value="2579"/> months	<input type="text" value="2580"/> years	<input type="text" value="2581"/> months
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> years	<input type="text"/> months	<input type="text"/> years	<input type="text"/> months
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> years	<input type="text"/> months	<input type="text"/> years	<input type="text"/> months
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> years	<input type="text"/> months	<input type="text"/> years	<input type="text"/> months

- 2575 - DietarySuppCode
- 2576 - DietarySuppDrops
- 2570 - DietarySuppMilliliter
- 2571 - DietraySuppTablet
- 2572 - DietraySuppOther
- 2573 - OtherDietarySuppCode
- 2577 - DIETARYSUPPNUMPERWEEK1_1
- 2578 - DietarySuppAgeStartagey
- 2579 - DietarySuppAgeStartagem
- 2580 - DietarySuppAgeStoppedYrs
- 2581 - DietarySuppAgeStopagem

7a. Acute Illnesses - Has the child been ill since the last visit? Record all chronic illnesses/conditions on the next page.

No Yes 2582

ChildIllSinceLastVisit

Date Illness first appeared	ICD-10 Code: ONLY code <u>Symptoms</u> here (ALWAYS CODE SYMPTOMS)	Fever? (temperature is equal to or higher than 38°C or 101°F) <u>Diagnosis: ICD-10 Code</u>
-----------------------------	--	---

No Symptoms

IllnessNoSymptoms1_1

4181

No 2739

IllnessDiagnosisCode1_1

Yes, Measured

Diagnosed by parent

2740

Yes, Not Measured

Diagnosed by health care provider

DATEILLNESSAPPEAREDAGE10_1

Illness Symptoms Codes

IllnessFever1_1

IllnessDiagnosis1_1

No Symptoms

No

Yes, Measured

Diagnosed by parent

Yes, Not Measured

Diagnosed by health care provider

No Symptoms

No

Yes, Measured

Diagnosed by parent

Yes, Not Measured

Diagnosed by health care provider

No Symptoms

No

Yes, Measured

Diagnosed by parent

Yes, Not Measured

Diagnosed by health care provider

No Symptoms

No

Yes, Measured

Diagnosed by parent

Yes, Not Measured

Diagnosed by health care provider

Add

7b. Chronic Illnesses - Since the last visit, has your child been diagnosed by a health care provider with any chronic illness or condition?

A chronic illness is a condition generally lasting 3 months or longer. It is permanent, long lasting or results in residual disability. A chronic disease can also be recurrent and relapse repeatedly with periods of remission.

No Yes 3743

ChildDiagnosedChronicIllness

Chronic illness/condition diagnosed by health care provider: ICD-10 Code	Date of diagnosis of chronic illness/condition by health care provider(MMM/YYYY)	Date chronic illness went into remission(MMM/YYYY)
--	--	--

3751	3744 3745	3746 3747

ChronicIllnessICD10Code1_1

Add

AGEDIAGNOSISCHRONICILLNESS1_1

AGECHRONICILLNESSREMISSION1_1

8. Medications Has the child been given any medications - any kind of prescription medication (oral, topical, injection, etc.) and/or oral "over the counter" medication, since the last visit? NOTE: Do not include vitamins and other dietary supplements here.

MedicationGivenToChildOrNot

No Yes 2595

Medication: Name	Medication: Code	Reason for medication: Code	How old was your child when they received this medication? (Age in years and months)	For how many days did you give the medication?
<input type="text" value="4113"/>	<input type="text" value="2596"/>	<input type="text" value="2597"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason 3111 for medication above	<input type="text" value="2600"/> years <input type="text" value="2601"/> months	<input type="text" value="2598"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed 2599 2594
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason 3118 for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed

- 4113 - MedicationName1_1
- 2596 - MedicationCode1_1
- 2597 - MedicationReasonCode1_1
- 3111 - MedNonTreatmentReason1_1
- 3118 - AddIReasonForMedAbove1_1
- Medications - Age when child received medication
- 2598 - NumDaysMedication1_1
- 2599 - MedicationOngoingOrNot1_1
- 2594 - MedicationAsNeeded1_1

9. Hospitalizations of the child

Has the child been in the hospital since the last visit?

ChildInHospitalSinceLastVisit

No Yes 2608

Date	Number of nights hospitalized	Reason for hospitalization Code	Do we have signed medical records authorization to view hospital charts?
------	-------------------------------	---------------------------------	--

2609	2613		2615
2610	2612 <input type="checkbox"/> ER visit only <input type="checkbox"/>	2614	<input type="radio"/> No <input type="radio"/> Yes
2611	Outpatient treatment 2602	ReasonHospitalizedCode1_1	HaveRightsToViewMedCharts1_1
	<input type="checkbox"/> ER visit only <input type="checkbox"/>		<input type="radio"/> No <input type="radio"/> Yes
	Outpatient treatment		<input type="radio"/> No <input type="radio"/> Yes
	<input type="checkbox"/> ER visit only <input type="checkbox"/>		<input type="radio"/> No <input type="radio"/> Yes
	Outpatient treatment		<input type="radio"/> No <input type="radio"/> Yes
Add	NumNightsHospitalized1_1	ERVisitOnly1_1	OutpatientTreatment1_1

Hospitalization Date1

10. Day care or Other Social Groups

We are interested in keeping track of those times that your child is regularly (once a week or more) around other children. This could be day care or other regular social get-togethers. Below is a place to record day care situations and the next page is for other social groups.

Day Care: Is the child at the present time in a new day care situation that includes at least 1 other child, who is not a sibling, or has anything changed in the day care situation since the last visit (change of day care facility, number of children in group, # of hours attended)?

No Yes 2630 **ChildInDayCareOrNot**

Don't forget to record the end date for any day care situations that may have stopped!

Date Started(MMM/YYYY)	Until(MMM/YYYY)	Type of daycare	Type of day care:Code	Hours per week attended	Total # of children in child's group/class
2631 2632	2633 2634	3712	2635	2636	2637
AttendedHrsPerWeek11_1					
NumChildrenChildGroup1_1					
DAYCARESTARTDATE1_1		TypeOfDaycare1_1	DayCareTypeCode11_1		
Add DAYCAREUNTILAGE11_1					

Social Groups: Does the child regularly (atleast once a week) participate in a new group activity with other children, who are not the child's siblings? Do not include day care. This could be a regular play group at your house or others, gymboree, swimming class, etc.

No Yes 2652 **ChildsParticipationSocialGroup**

Date Started (MMM/YYYY)	Until(MMM/YYYY)	Type of social group	Type of social group:Code	Hours per week attended	Total # of children in child's group
2653 2654	2655 2656	3713	2657	2658	2659
SocialNumChildGroup11_1					
SOCIALSTARTAGE110_1		TypeOfSocialGroup1_1	SocialGroupTypeCode11_1	SocialAttendHrsPerWeek11_1	
Add SOCIALUNTILAGE110_1					

English Teleform	Swedish Teleform	German Teleform	Finnish Teleform	Spanish Teleform
------------------	------------------	-----------------	------------------	------------------

TEDDY

The Environmental Determinants of Diabetes in the Young

Teddy Calendar for 6-9 year olds

Data Extraction Form

* These fields are required in order to SAVE the form.

* These additional fields are required in order to make the form complete.

Subject ID	Date of Birth
Local Code	Date of Registration
Status	Clinical Center

Valid date range for this visit : **13 Nov 2013** until **12 May 2014**.

Interview Date	* <input type="text"/>	Visit Location Code	* <input type="text"/>
TEDDY Staff Code	* <input type="text"/>	event_age	

Visit

6 Years 3 Months
 6 Years 6 Months
 6 Years 9 Months
 7 Years
 7 Years 3 Months
 7 Years 6 Months
 7 Years 9 Months
 8 Years
 8 Years 3 Months
 8 Years 6 Months
 8 Years 9 Months
 9 Years

Persons(s) Interviewed

Father
 Mother
 Other Primary Caretaker
 Other

Persons(s) Interviewed Other Code

1. Allergies Does the child have any new allergies (including any allergies to dust, animals, foods, etc)? *

No (Continue to the next section)
 Yes (fill in the table)
 4315

The child is allergic to:	Code	When did the allergy start? (Age in years and months)	If the allergy has stopped, when did it stop (Age in years and months)?	Code	Recommended by a health care provider?	If health care provider told caretaker child has allergy, how was it diagnosed?
ChildAllergy1_1	AllergyCode1_1	<input type="text" value="4269"/> years <input type="text" value="4270"/> months AllergyStartedMonths11_1	<input type="text" value="4268"/> years <input type="text" value="4275"/> months AllergySymptomsCode11_1	<input type="text" value="4276"/> <input type="text" value="4271"/> <input type="text" value="4272"/> <input type="text" value="4273"/>	<input type="radio"/> No <input type="radio"/> Yes	4266 <input type="radio"/> Skin test DiagnosisType1_1 4274 RecommByHealthCareProvider1_1 <input type="radio"/> Blood test <input type="radio"/> Challenge test <input type="radio"/> Other clinical test <input type="radio"/> No clinical test was done <input type="radio"/> Do not know whether test was done
ChildAllergy2_1	AllergyCode2_1	<input type="text"/> years <input type="text"/> months AllergyStartedMonths21_1	<input type="text"/> years <input type="text"/> months AllergySymptomsCode21_1	<input type="text"/> <input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes	4274 RecommByHealthCareProvider2_1 <input type="radio"/> Blood test DiagnosisType2_1 <input type="radio"/> Skin test <input type="radio"/> Challenge test <input type="radio"/> Other clinical test <input type="radio"/> No clinical test was done <input type="radio"/> Do not know whether test was done
ChildAllergy3_1	AllergyCode3_1	<input type="text"/> years <input type="text"/> months AllergyStartedMonths31_1	<input type="text"/> years <input type="text"/> months AllergySymptomsCode31_1	<input type="text"/> <input type="text"/>	<input type="radio"/> No <input type="radio"/> Yes	4274 RecommByHealthCareProvider3_1 <input type="radio"/> Blood test DiagnosisType3_1 <input type="radio"/> Skin test <input type="radio"/> Challenge test <input type="radio"/> Other clinical test <input type="radio"/> No clinical test was done <input type="radio"/> Do not know whether test was done

2. All Special Diets: Is the child on any new diets?*

No (Did they stop a diet they were previously on? If yes, fill in stopped at age.)

Yes (fill in the table)

4695

IsChildOnNewDiets

Type of Diet	Started (years and months)	Stopped (years and months)	Recommended by a health care provider?
a. Avoidance of cow's milk and milk products due to allergy in the child	4309 years 4310 months	4311 years 4312 months	<input type="radio"/> No <input type="radio"/> Yes 4293 <i>CowMilkAvoidSuggestedByProvide</i>
b. Cereal or wheat avoidance due to allergy in the child	4313 years 4314 months	4299 years 4300 months	<input type="radio"/> No <input type="radio"/> Yes 4294 <i>CerealAvoidSuggestedByProvider</i>
c. Gluten-free diet due to celiac disease in the child	4301 years 4302 months <i>GlutenFreeDietStartedMon GlutenFreeDietStartedYrs</i>	4303 years 4304 months <i>GlutenFreeDietStoppedMon GlutenFreeDietStoppedYrs</i>	<input type="radio"/> No <input type="radio"/> Yes 4295 <i>GlutenfreeDietProvider</i>
d. Vegetarian Diet What types of food does the child eat on this vegetarian diet? (Mark all that apply)			
<input type="checkbox"/> Plant products <i>TypeOfFoodChildHasVe_Plantproducts</i>	4305 years 4306 months	4307 years 4308 months	<input type="radio"/> No <input type="radio"/> Yes 4296 <i>VegeDietSuggestedByHealthCare</i>
<input type="checkbox"/> Milk and milk products 4297			
<input type="checkbox"/> Eggs <i>TypeOfFoodChildHasVe_Eggs</i>			
<input type="checkbox"/> Fish <i>TypeOfFoodChildHasVe_Fish</i>			
<i>VegetarianDietStartedYrs VegetarianDietStartedMon</i>		<i>VegetarianDietStoppedYrs VegetarianDietStoppedMon</i>	

Other Diet (Specify and Code)	Started (years and months)	Stopped (years and months)	Recommended by a health care provider?
4322 4321	4316 years 4317 months	4318 years 4319 months	<input type="radio"/> No <input type="radio"/> Yes 4320 <i>OtherDietRecommendedbyprovi1_1</i>
<input type="button" value="Add"/> <i>OtherDietSpecify1_1</i> <i>OtherDietCode1_1</i>			

4. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 4697

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

No Yes 4698

ChildsVacinatIonCardChecked

Vaccination	Date of vaccine (DD / MMM / YYYY)		Date of vaccine (DD / MMM / YYYY)			Date of vaccine (DD / MMM / YYYY)			Date of vaccine (DD / MMM / YYYY)			Date of vaccine (DD / MMM / YYYY)		
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	4333	4334	4336	4337	4338	4339	4340	4341	4371	4372	4373	4374	4375	4330
	4335													
OR Diphtheria Tetanus (Td/DT)	4342	4343	4345	4346	4347	4348	4349	4350	4331	4332	4376	4377	4378	4362
	4344													
Polio (OPV or IPV)	4351	4352	4354	4355	4359	4360	4361	4699	4363	4364	4365	4633	4634	4635
	4353													
Haemophilus influenzae B (HiB)	4709	4356	4358	4366	4367	4368	4369	4370	4379	4438	4439	4703	4704	4702
	4357													
Measles, Mumps, Rubella (MMR)	4380	4381	4383	4384	4385	4409	4410	4708	4636	4640	4639	4641	4637	4638
	4382													
Hepatitis A	4411	4412	4414	4415	4416	4417	4418	4419	4444	4445	4446	4447	4448	4449
	4413													
Hepatitis B (HB)	4386	4387	4389	4390	4391	4392	4393	4394	4443	4407	4408	4705	4706	4707
	4388													
Hepatitis A&B (combination)	4420	4421	4423	4424	4425	4426	4427	4428	4450	4451	4452	4453	4454	4455
	4422													
Varicella (Chicken Pox)	4395	4396	4621	4622	4623	4624	4625	4626	4627	4628	4629	4630	4631	4632
	4397													
Injectable Influenza	4429	4430	4432	4433	4434	4435	4436	4437	4456	4457	4458	4459	4460	4461
	4431													
Nasal Influenza	4645	4646	4648	4649	4650	4651	4652	4653	4654	4655	4659	4656	4657	4658
	4647													
Human Papillomavirus (HPV)	4660	4661	4663	4664	4665	4666	4667	4668	4669	4670	4671	4672	4673	4674
	4662													

Other Code	Date of vaccine														
4725	4710	4711	4712	4713	4714	4715	4716	4717	4718	4719	4720	4721	4722	4723	4724
Add															

4. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 4697

ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?

No Yes 4698

ChildsVaccinationCardChecked

Vaccination (For Finland)	Rokotuspäivä (PV/KK/VVVV)				
Tuhkarokko, sikotauti, vihurirokko (MPR)	5016 5017 5018	5019 5020 5021	5022 5023 5024	5025 5026 5027	5040 5041 5042
Hepatiitti A (HAV)	4963 4964 4965	4966 4967 4968	4969 4970 4971	4972 4973 4974	4975 4976 4977
Hepatiitti B (HBV)	5028 5029 5030	5031 5032 5033	5034 5035 5036	5043 5044 5045	5046 5047 5048
Hepatiitti A ja Hepatiitti B (HAV ja HBV -yhdistelmä)	4978 4979 4980	4981 4982 4983	4984 4985 4986	4987 4988 4989	4990 4991 4992
Puutiaisaivotulehdus (TBE)	4993 4994 4995	4996 4997 4998	4999 5000 5001	5002 5003 5004	5005 5006 5007
Influenssa (käytetään, kun influenssarokote on annettu pistoksena; koodia V0037 käytetään, kun influenssarokote on annettu nenän kautta)	5008 5009 5010	5011 5012 5013	4956 4957 4958	4959 4960 4961	4962 5014 5015
Vesirokko	5037 5038 5039	5049 5050 5057	5052 5053 5054	5055 5056 5057	5058 5059 5060
Ihmisen papillomavirus (HPV)	4757 4728 4727	4729 4730 4731	4732 4733 4734	4735 4736 4737	4738 4739 4740

Muu	Rokotuspäivä	Rokotuspäivä	Rokotuspäivä	Rokotuspäivä	Rokotuspäivä
4741	4742 4743 4744	4745 4746 4747	4748 4749 4750	4751 4752 4753	4754 4755 4756

Add

4. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 4697 ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?
 No Yes 4698 ChildsVaccinationCardChecked

Vaccination (For Germany)	Datum der Impfung (TT/MMM/JJJJ)														
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	5095	5096	5097	5098	5099	5100	5101	5102	5103	5104	5105	5106	5107	5108	5109
ODER Diphtheria Tetanus (Td/DT)	5110	5111	5112	5113	5114	5115	5116	5117	5118	5119	5120	5121	5122	5123	5124
Polio (OPV or IPV)	5125	5126	5127	5128	5129	5077	5078	5079	5076	5081	5082	5080	5064	5065	5066
Haemophilus influenzae B (HiB)	5083	5084	5085	5086	5087	5088	5089	5090	5091	5092	5093	5094	5067	5068	5069
Masern, Mumps, Röteln (MMR)	5130	5131	5132	5133	5134	5135	5136	5137	5138	5139	5140	5141	5142	5143	5144
Hepatitis A	5154	5155	5156	5157	5158	5159	5160	5161	5162	5163	5164	5165	5166	5167	5177
Hepatitis B (HB)	5145	5146	5147	5148	5149	5150	5151	5152	5153	5070	5071	5072	5073	5074	5075
Hepatitis A&B (Kombination)	5168	5169	5170	5171	5172	5173	5174	5175	5176	5178	5179	5180	5181	5182	5183
Varizellen (Windpocken)	5184	5185	5186	5061	5062	5063	5187	5188	5189	5190	5191	5192	5193	5194	5195
Grippe (Influenza) (Grippeimpfung (Influenza, intramuskuläre Injektion); Code V0037 sollte bei nasaler Grippeimpfung angegeben werden.)	5196	5197	5198	5199	5200	5201	5202	5203	5204	5205	5206	5207	5208	5209	5210
Human Papillomavirus (HPV)	5211	5212	5213	5214	5215	5216	5217	5218	5219	5220	5221	5222	5223	5224	5225

Anderes	Datum der Impfung														
5240	5226	5227	5228	5229	5230	5231	5232	5233	5234	5235	5236	5237	5241	5238	5239

Add

4. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*

No Yes 4697 ChildGivenVaccineOrNot

Was the child's vaccination card checked by the TEDDY staff member?
 No Yes 4698 ChildsVaccinationCardChecked

Vaccination Sweden	(For	Datum för vaccination (DD/MMM/ÅÅÅÅ)				
Difteri		4760 4761 4762	4763 4764 4765	4766 4767 4768	4769 4770 4771	4772 4773 4774
Stelkramp		4775 4776 4777	4778 4779 4780	4781 4782 4783	4889 4784 4785	4786 4787 4788
Kikhosta		4789 4790 4791	4792 4793 4794	4795 4796 4797	4798 4789 4800	4801 4802 4803
MPR (mässling, påssjuka, röda hund)		4909 4910 4911	4912 4913 4914	4915 4916 4917	4804 4805 4806	4807 4808 4809
Vattkoppor		4978 4919 4920	4921 4922 4923	4924 4925 4926	4810 4811 4812	4813 4814 4815
Polio		4927 4928 4929	4930 4931 4932	4933 4934 4935	4953 4954 4952	4816 4817 4818
Hepatit A (endast)		4890 4891 4892	4893 4894 4895	4896 4987 4898	4822 4823 4824	4819 4820 4821
Hepatit B (endast)		4899 4900 4901	4902 4903 4904	4905 4906 4907	4828 4829 4830	4825 4826 4827
Hepatit A & B (kombination)		4908 4936 4937	4938 4939 4940	4941 4942 4943	4834 4835 4836	4831 4832 4833
Influensa (Endast för influensa vaccin som injiceras; kod V0037 ska användas för influensa vaccin som inhaleras)		4944 4945 4946	4947 4948 4949	4950 4955 4951	4840 4842 4841	4837 4838 4839
TBE ("Fästingvaccination")		4855 4856 4857	4852 4853 4854	4849 4850 4851	4846 4847 4848	4843 4844 4845
Human Papillomavirus (HPV)		4870 4871 4872	4867 4868 4869	4864 4865 4866	4861 4862 4863	4858 4859 4860

Annan, vad? Kod	Datum för vaccination				
4888	4873 4874 4875	4876 4877 4878	4879 4880 4881	4882 4883 4884	4885 4886 4887
Add					

- DifteriDay1
- DifteriMonth1
- DifteriYear1
- DifteriDay2
- DifteriMonth2
- DifteriYear2
- DifteriDay3
- DifteriMonth3
- DifteriYear3
- StelkrampDay1
- StelkrampMonth1
- StelkrampYear1
- StelkrampDay2
- StelkrampMonth2
- StelkrampYear2
- StelkrampDay3
- StelkrampMonth3
- StelkrampYear3
- KikhostaDay1
- KikhostaMonth1
- KikhostaYear1
- KikhostaDay2
- KikhostaMonth2
- KikhostaYear2

- KikhostaDay3
- KikhostaMonth3
- KikhostaYear3
- PolioDay1
- PolioMonth1
- PolioYear1
- PolioDay2
- PolioMonth2
- PolioYear2
- PolioDay3
- PolioMonth3
- PolioYear3
- HaemofilusInfluenzaBDay1
- HaemofilusInfluenzaBMonth1
- HaemofilusInfluenzaBYear1
- HaemofilusInfluenzaBDay2
- HaemofilusInfluenzaBMonth2
- HaemofilusInfluenzaBYear2
- HaemofilusInfluenzaBDay3
- HaemofilusInfluenzaBMonth3
- HaemofilusInfluenzaBYear3

5. Dietary Supplements - Has the child been given any new single vitamins, multivitamins, or other dietary supplements (such as fish oils, antioxidants, or others) since the last visit? 4541 **DietarySupp**

No (Did they stop taking a dietary supplement they were previously on? If yes, fill in the stopped at age.) Yes (fill in the table)

Type of preparation and Brand Name:Code	drop(s)	milliliter(s)	tablet(s)	Other	Other Code	How many times a week?	Started (Age in years and months)		Stopped (Age in years and months)					
							years	months	years	months				
4534	4535	4530	4531	4532	4533	4536	4537	years	4538	months	4539	years	4540	months
								years		months		years		months
								years		months		years		months
								years		months		years		months

- 4534 - DietarySuppCode10_1
- 4535 - DietarySuppDrops10_1
- 4530 - DietarySuppMilliliters10_1
- 4531 - DietraySuppTablets10_1
- 4532 - DietraySuppOther10_1
- 4533 - OtherDietarySuppCode10_1
- 4536 - DietarySuppNumPerWeek10_1
- 4537 - DietarySuppAgeStartedYrs4_1
- 4538 - DietarySuppAgeStartedMon4_1
- 4539 - DietarySuppAgeStoppedYrs4_1
- 4540 - DietarySuppAgeStoppedMon4_1

6a. Acute Illnesses - Has the child been ill since the last visit? Record all chronic illnesses/conditions on the next page.

No (Continue to the next section)

Yes (fill in the table)

ChildIllSinceLastVisit

4552

Date Illness first appeared	ICD-10 Code: ONLY code <u>Symptoms</u> here (ALWAYS CODE SYMPTOMS)	Fever? (temperature is equal to or higher than 38°C or 101°F) <u>Diagnosis: ICD-10 Code</u>
-----------------------------	--	---

4542 4543 4547 4548 4549 4550 No Symptoms 4551

4554 No 4546 Diagnosed by parent Diagnosed by health care provider

Date Illness first appeared IllnessSymptomCode1
IllnessSymptomCode2
IllnessSymptomCode3

No Symptoms

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured 4545

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Symptoms

No Diagnosed by parent Diagnosed by health care provider

Yes, Measured Diagnosed by parent Diagnosed by health care provider

Yes, Not Measured Diagnosed by health care provider

No Diagnosed by parent Diagnosed by health care

Yes, Measured Diagnosed by parent Diagnosed by health care

6b. Chronic Illnesses - Since the last visit, has your child been diagnosed by a health care provider with any chronic illness or condition?

A chronic illness is a condition generally lasting 3 months or longer. It is permanent, long lasting or results in residual disability. A chronic disease can also be recurrent and relapse repeatedly with periods of remission.

No (Continue to the next section)

Yes (Fill in the table)

4558

ChildDiagnosedChronicIllness

Chronic illness/condition diagnosed by health care provider: ICD-10 Code	Date of diagnosis of chronic illness/condition by health care provider(MMM/YYYY)	Date chronic illness went into remission(MMM/YYYY)
--	--	--

4553	4554 4555	4556 4557

ChronicIllnessICD10Code1_1

Date of Diagnosis of Chronic Illness

Date Chronic Illness went into Remission

Add

7. Medications Has the child been given any medications - any kind of prescription medication (oral, topical, injection, etc.) and/or oral "over the counter" medication, since the last visit? NOTE: Do not include vitamins and other dietary supplements here.

MedicationGivenToChildOrNot

No (Continue to the next section) Yes (fill in the table) 4569

Medication: Name	Medication: Code	Reason for medication: Code	How old was your child when they received this medication? (Age in years and months)	For how many days did you give the medication?
<input type="text" value="4560"/>	<input type="text" value="4561"/>	<input type="text" value="4562"/> <input type="checkbox"/> Non-treatment reason <small>4565</small>	<input type="text" value="4567"/> years <input type="text" value="4568"/> months	<input type="text" value="4563"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed <small>4564 4559</small>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason <small>4566</small> for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/> years <input type="text"/> months	<input type="text"/> <input type="checkbox"/> Ongoing <input type="checkbox"/> As needed
<input type="button" value="Add"/>				

- 4113 - MedicationName1_1
- 2596 - MedicationCode1_1
- 2597 - MedicationReasonCode1_1
- 3111 - MedNonTreatmentReason1_1
- 3118 - AddlReasonForMedAbove1_1
- Medications - Age when child received medication
- 2598 - NumDaysMedication1_1
- 2599 - MedicationOngoingOrNot1_1
- 2594 - MedicationAsNeeded1_1

8. Hospitalizations of the child

Has the child been in the hospital since the last visit?

No (Continue to the next section)

Yes (fill in the table)

4571

ChildInHospitalSinceLastVisit

Date	Number of nights hospitalized	Reason for hospitalization Code	Do we have signed medical records authorization to view hospital charts?
4572	4573	4575 <input type="checkbox"/> ER visit only <input type="checkbox"/>	4578 <input type="radio"/> No <input type="radio"/> Yes
4574	4570	4577	HaveRightsToViewMedCharts1_1
Hospitalization Date1	Outpatient treatment	ReasonHospitalizedCode1_1	
	<input type="checkbox"/> ER visit only <input type="checkbox"/>		<input type="radio"/> No <input type="radio"/> Yes
	Outpatient treatment		<input type="radio"/> No <input type="radio"/> Yes
	<input type="checkbox"/> ER visit only <input type="checkbox"/>		<input type="radio"/> No <input type="radio"/> Yes
	Outpatient treatment		<input type="radio"/> No <input type="radio"/> Yes
	NumNightsHospitalized1_1	ERVisitOnly1_1	OutpatientTreatment1_1
Add			

English Teleform	German Teleform	Swedish Teleform	Finnish Teleform	Spanish Teleform
------------------	-----------------	------------------	------------------	------------------

TEDDY
The Environmental Determinants of Diabetes in the Young

Primary Caretaker Interview
3 Month Clinic Visit

* These fields are required in order to SAVE the form.
 * These additional fields are required in order to make the form complete.

Subject ID		Date of Birth	
Local Code		Date of Registration	
Status		Clinical Center	

Interview Date	620 621 622 *	Visit Location Code	*
----------------	---------------	---------------------	---

TEDDY Staff Code * event_age

642

Person(s) Interviewed
 Father Mother Other Primary Caretaker Other
 Code 644

1. Was your baby born within a week of the due date? BabyBornWithinWeek_DueDate
 No Yes Don't know 440

If No, was your baby born before or after the due date?
BabyBornAfterDueDate Before due date After-due date 441

If before, how many weeks before the due date?
 442 BabyBorn_WeeksBeforeDueDate

If after, how many days after the due date?
 443 BabyBorn_DaysAfterDueDate

(For Sweden, Finland and Germany) 1. During which week of pregnancy was the baby born, i.e. how long was the pregnancy?
 1531 weeks 1532 days Don't know 1533

2. What was your baby's birth weight ? BabysWeightPounds
 444 pound(s) 445 ounces **OR** 1512 gms Don't Know 446

3. What was your baby's birth length ? BabysLengthInches
 447 inches **OR** 1513 cms Don't Know BabysLengthDontKnow 448

4. What was your baby's 5 minute Apgar score? Baby5MinuteApgarScore
 409 score Don't Know BabyApgarScoreDontKnow 410

5. How was your baby delivered? NormalVagina 411

HowWasBabyDelievered_

<input type="checkbox"/> Normal vaginal	<input type="checkbox"/> Breech Breech
<input type="checkbox"/> Caesarian section Caseariansec	<input type="checkbox"/> Vacuum extraction VacuumExtrac
<input type="checkbox"/> Forceps Extraction ForcepsExtra	<input type="checkbox"/> Other other

Code
 651 BabyDeliveredCode1_1
Other Codes
 1925

6. Since your baby was born, did he/she have any of the conditions listed below?*			
a. Difficulty breathing/respiration problems	BreathingRespirationProblems	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	413
b. Cold or runny nose	ColdRunnyNose	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	414
c. Ear infection	EarInfection	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	449
d. Blood infection (sepsis)	BloodInfection	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	416
e. Pneumonia	Pneumonia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	417
f. Diarrhea	Diarrhea	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	418
g. Eye discharge	EyeDischarge	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	419
h. Rash	Rash	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	420
i. Meningitis	Meningitis	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	415
j. Other infection or fever	OtherInfectionFever	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	421
k. Parasites (worm infection)	Parasites	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	450
l. Yellow skin (jaundice)	Jaundice	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	422
m. Blood group incompatibility (Rh or ABO)	BloodGroupIncompatibility	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	423
n. Blood transfusion	BloodTransfusion	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	424
o. Light therapy (photo therapy)	LightTherapy	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	425
p. Anemia (low iron in the blood)	Anemia	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	426
q. Birth defect (congenital abnormality)	BirthDefect	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	427
r. Birth trauma (injury to baby during birth)	BirthTrauma	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	428
s. Meconium aspiration	MeconiumAspiration	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	429
t. Periods of no breathing (apnea)	PeriodsNoBreathing	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	430
u. Edema or swelling	EdemaSwelling	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	431
v. Seizures	Seizures	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	432
w. Low blood sugar (hypoglycemia)	LowBloodSugar	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	433
x. Bloody stool	BloodyStool	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	434
y. Bleeding	Bleeding	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	435
z. Surgery	Surgery	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	436
aa. Failure to thrive(failure to gain weight)	FailureToThrive	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	645
bb. Other	<p>ICD- 10 Code <input type="text" value="439"/> OtherConditionCode</p> <p>More ICD-10 Codes</p> <p><input type="text" value="1876"/> MoreOtherCodes1_1</p> <p><input type="text"/></p> <p><input type="button" value="Add"/></p>	<p>437 OtherCondition</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know</p>	

7. Has your child ever been hospitalized (except at delivery)?

No Yes 451 ChildEverHospitalized

a. If Yes, why? ICD-10 Code ChildHospitalizedWhy

From

Until

ICD-10 Codes From Until

ICD-10 Codes	From	Until
<input type="text" value="1914"/>	<input type="text" value="1915"/> <input type="text" value="1916"/>	<input type="text" value="1918"/> <input type="text" value="1919"/>
<input type="text"/>	<input type="text" value="1917"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

ChildEverHospDynCode1_1

Add

ChildHospFromDynDay1_1 ChildHospUntilDynDay1_1

b. Can we look at the child's medical chart? 462 CanWeSeeMedicalChart

No Yes

8. Has your child been given any medications - any kind of prescription medication (oral, topical, injection, etc.) and/or oral "over the counter" medication?

If yes, please tell me what your child has taken. Do not include vitamins and other dietary supplements here. ChildGivenMedications

623 No Yes

Medication Name	Name:Code	Reason:Code	Age started (weeks)	Still taking	As needed	For how many days?
<input type="text" value="1934"/>	<input type="text" value="464"/>	<input type="text" value="466"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason 3112	<input type="text" value="467"/>	<input type="checkbox"/> 469	<input type="checkbox"/> 2154	<input type="text" value="468"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above 3116	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Non-treatment reason <input type="checkbox"/> Additional reason for medication above	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

MedicationName1_1

MedicationReason

MedicationStillTaking1_1

MedicationAsNeeded1_1

Add

9. Does your baby get any breast-milk now?* 472

No, my baby has not been breast fed at all.
 No, breast feeding was ended at the age of:
 Yes **BabyGetBreastMilkNow**

days OR weeks
BreastFeedingEndedAtAge_Days
BreastFeedingEndedAtAge_Weeks

10. Has your baby been given donated (banked) breast-milk?*

BabyGivenDonatedBreastMilk No Yes 473

Please indicate the age started: days or weeks

And age stopped: days or weeks

11. Has your baby been given infant formula(s)? Please remember to indicate small amounts of formula, such as when you mix it into food.*

No Yes 478

BabyGivenInfantFormula

Code	Ready to feed, Powder or Liquid Concentrate?	Started at Age(weeks)	Stopped at Age (weeks)	Still receiving	Why did you Change formula types?Code
<input type="text" value="481"/>	<input type="radio"/> Ready to feed Powder_Liquid <input type="radio"/> Powder 480 <input type="radio"/> Liquid concentrate	<input type="text" value="482"/>	<input type="text" value="483"/>	<input type="checkbox"/> 484	
					InfantFormula_StartAge InfantFormula_StopAge InfantFormula_StillReceiving
<input type="text"/>	<input type="radio"/> Ready to feed <input type="radio"/> Powder <input type="radio"/> Liquid concentrate	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="646"/> <input type="text" value="1973"/>
					WhyChangedFormulaBrandCode ChangdFormulaBrandTypeCode2
<input type="text"/>	<input type="radio"/> Ready to feed <input type="radio"/> Powder <input type="radio"/> Liquid concentrate	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="radio"/> Ready to feed <input type="radio"/> Powder <input type="radio"/> Liquid concentrate	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="button" value="Add"/>					

12. What kind of drinking water does your baby usually get?* 486

- Tap water from the city
- Tap water from own well or spring
- Tap water, but do not know where water comes from
- Bottled water from the store
- Other kind of water
- Baby is not given water

KindOfDrinkingWaterBabyGets

Code

DrinkingWaterChildOther
DrinkingWaterChildOtherCode1_1

Other Codes

TypeWaterBabyDrinkCode

Add

12a. Was this water filtered? 697

- No
- Yes

WasDrinkingWaterFiltered

13. What kind of water do you usually use when you're making food for your baby? 489

- Tap water from the city
- Tap water from own well or spring
- Tap water, but do not know where water comes from
- Bottled water from the store
- Other kind of water
- Baby is not given food that includes added water

KindOfWaterInFoodForBaby

Code

TypeWaterPrepFoodCode

Other Codes

WaterInCookedFoodForChildOther

CookingWaterOtherCode1_1

Add

13a. Was this water filtered? 698

- No
- Yes

WasCookingWaterFiltered

14. Has your baby been given any dietary supplements such as single vitamins, multivitamins, multiminerals, or other dietary supplements (such as fish oils, antioxidants, or others)?

No Yes 492

BabyGivenMultiVitaminsFishOil

Type of preparation, Brand name:Code	drop(s)	droppers(s)	milliliter(s)	tablet(s)	Other	Other Code	How many times a week?	Started (age in weeks)	Still taking	Stopped (age in weeks)
504	1518	1519	1520	1521	1522	1523	505	506	<input type="checkbox"/> 508	509
									<input type="checkbox"/>	
									<input type="checkbox"/>	
									<input type="checkbox"/>	
									<input type="checkbox"/>	
									<input type="checkbox"/>	
									<input type="checkbox"/>	

Add

- 504- DietarySuppCode1_1
- 1518- DietarySuppDrops1_1
- 1519- DietarySuppDroppers1_1
- 1520- DietarySuppMilliliters1_1
- 1521- DietarySuppTablets1_1
- 1523- DietarySuppOtherCode1_1
- 505- DietarySuppWeekly
- 506- DietarySuppStartAge
- 508- DietarySuppStillTaking
- 509-DietarySuppStoppedAge

15. Up until today, has your baby been given any food or drinks other than breast milk or formula?*

No Yes 567

BabyGivenFoodOtherThanBreastMi

Food Item	Age in weeks	Food Item	Age in weeks						
1. Apple sauce or apple juice AppleSauceJuice	532	18. Oat (cereals, porridge, bread, teething biscuits, made with oat flour) Oat	549						
2. Fruit or berries (purees and juices- except apple sauce or apple juice) FruitBerries	533	19. Rye (cereals, porridge, bread, teething biscuits, made with rye flour) Rye	550						
3. Potatoes Potatoes	534	20. Buckwheat and millet (cereals, porridge, bread, tortillas, and teething biscuits made with this type of flour)	551						
4. Sweet potatoes or yams SweetPotatoesYams	535	21. Pork, beef PorkBeef	552						
5. Carrots Carrots	536	22. Poultry Poultry	553						
6. Spinach Spinach	537	23. Other kinds of meat (e.g. lamb, deer, reindeer) OtherMeat	554						
7. Beets Beets	538	24. Sausage / hot dogs SausageHotDogs	555						
8. Peas / green beans PeasGreenBeans	539	25. Fish and other seafood FishOtherSeaFood	556						
9. Turnip/parsnip/artichoke/rutabaga/jerusalem TurnipsParsnipArtichoke	540	26. Egg Egg	557						
10. Cabbages (Chinese cabbage, red cabbage, cauliflower, broccoli, kale, cabbage turnip, collard, mustard or turnip greens) Cabbages	541	27. Milk products (cheese, sour cream, yogurt, cottage cheese), commercial baby foods containing yogurt or cottage cheese MilkProducts	558						
11. Squash/pumkin SquashPumpkin	542	28. Regular cow's milk or ice cream (remember to include milk used in cooking) RegularCowMilkIceCream	559						
12. Tomato or tomato sauce TomatoTomatoSauce	543	29. Commercial baby food containing milk or infant formula (e.g. children's ready made cereals, porridges, and porridge powders) CommercialBabyFood	560						
13. Corn (sweet corn and cereals, porridge, bread, tortillas, and biscuits made with corn flour) Corn	544	30. Soy milk and other soy soy products SoyMilk	561						
14. Other vegetable OtherVegetable	545	31. Rice milk RiceMilk	562						
15. Rice (cereals, porridge, bread, teething biscuits, crackers, cookies, and pasta made with rice flour) Rice	546	32. Goat/Horse/Sheep milk GoatMilk	563						
16. Wheat (cereals, porridge, bread, teething biscuits, crackers, tortillas, cookies, and pasta made with wheat flour) Wheat	547	33. Code <input type="text" value="566"/> <input type="text" value="564"/> OtherFoodIntro <table border="1" style="margin-left: 20px;"> <thead> <tr> <th>More Codes</th> <th>Age</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td> <td><input type="text" value="1913"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table> OtherFoodThanBreastMilkAge Code <input type="button" value="Add"/>	More Codes	Age	<input type="text"/>	<input type="text" value="1913"/>	<input type="text"/>	<input type="text"/>	
More Codes	Age								
<input type="text"/>	<input type="text" value="1913"/>								
<input type="text"/>	<input type="text"/>								
17. Barley (cereals, porridge, bread, teething biscuits, made with barley flour) Barley	548								

16. We want to know about diets that you may have your child on for any reason. For each diet we want to know when you started the diet, whether your child is still on the diet or when you stopped the diet, and if a health care provider told you to put your child on this diet. If this is a vegetarian diet, we want to know what types of food your child eats on this diet.*

Type of Diet	What was the child's age in weeks when you started your child on this diet?	What was the child's age in weeks when the diet was stopped?	Did a health care provider tell you to put your child on this diet?
a. Cow's milk avoidance due to allergy in the child Not on diet <input type="checkbox"/> CowMilkAvoidance_NotOnDiet 589	<input type="text" value="590"/> CowMilkAvoidance_ChildStartAge	592 <input type="checkbox"/> Still on diet <input type="text" value="591"/> CowMilkAvoid_ChildAgeDietStopped	<input type="radio"/> No <input type="radio"/> Yes CowMilkAvoid_SuggestedByProvider
b. Cereal or wheat avoidance due to allergy in the child <input type="checkbox"/> Not on diet 594 CerealWhatAvoidance_NotOnDiet	<input type="text" value="595"/> _AgeStarted	597 <input type="checkbox"/> Still on diet <input type="text" value="596"/> _StoppedAge	<input type="radio"/> No <input type="radio"/> Yes CerealAvoid_SuggestedByProvider
c. Gluten-free diet due to celiac disease in the child <input type="checkbox"/> Not on diet 599 GlutenFreeDiet_NotOnDiet	<input type="text" value="600"/> _AgeStarted	<input type="checkbox"/> Still on diet _StillOnDiet <input type="text" value="601"/> _AgeStopped	<input type="radio"/> No <input type="radio"/> Yes _Provider 603
d. Vegetarian diet <input type="checkbox"/> Not on diet 604 VegeterianDiet_NotOnDiet What types of food does your child eat on this vegetarian diet? (Mark all that apply) <input type="checkbox"/> Plant products <input type="checkbox"/> Milk and milk products 609 <input type="checkbox"/> Eggs <input type="checkbox"/> Fish TypeOfFoodChildHas_VegeDiet	<input type="text" value="605"/> VegeterianDiet_StartAge	607 <input type="checkbox"/> Still on diet <input type="text" value="606"/> VegeDiet_StillOnDiet VegeterianDiet_StopAge	<input type="radio"/> No <input type="radio"/> Yes VegeDiet_SuggestedByHealthCare 608
e. Kosher Diet <input type="checkbox"/> Not on diet 610 diet KosherDiet_NotOnDiet	<input type="text" value="611"/> _StartAge	613 <input type="checkbox"/> Still on diet <input type="text" value="612"/>	<input type="radio"/> No <input type="radio"/> Yes _SuggestedByHealthCare 614
f. Other Diet: Code <input type="text" value="637"/> 615 OtherDietCode1_1 <input type="checkbox"/> Not on diet OtherDiet_NotOnDiet	<input type="text" value="636"/>	618 <input type="checkbox"/> Still on diet <input type="text" value="617"/>	<input type="radio"/> No <input type="radio"/> Yes SuggestedByHealthCare 619

Other Diet Code	Age Started	Age Stopped	Diet Suggested by health care provider
<input type="text" value="1928"/>	<input type="text" value="1930"/>	<input type="text" value="1931"/> <input type="checkbox"/> Still on diet 1932	<input type="radio"/> No <input type="radio"/> Yes 1933
<input type="button" value="Add"/>	_AgeStarted	_AgeStopped _StillOnDiet	_SuggestedByHealthCare1_1

17. Here is a list of a number of life experiences people sometimes have. Did you experience any of these during your pregnancy or since the birth of your child? *?* * DuringPregnancyNoLifeExp

No life experiences 699

Event Number	If event occurred during pregnancy, mark the trimester	If event occurred since the birth, list the age of child (in weeks)	Impact on you? <small>LifeExpPeopleHave_ImpactOnYou</small>	Impact on the child? <small>LifeExpPeopleHave_ImpactOnChild</small>	Continuous life event?
<input type="text" value="580"/>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester	<input type="text" value="582"/>	<input type="radio"/> Good 583 <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good 584 <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	ParentLifeExpContinuousLifeEvent 2080 <input type="checkbox"/> Yes
<input type="text"/>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester	<input type="text"/>	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="checkbox"/> Yes
<input type="text"/>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester	<input type="text"/>	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="checkbox"/> Yes
<input type="text"/>	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester	<input type="text"/>	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="checkbox"/> Yes

LifeExpPeopleHaveEventNum

Add

Specify other events 21) Code	<input type="text" value="639"/>	ParentsLifeOtherEvents1 ParentLife_OtherEvents_Code2 _Code3 _Code4 _Code5 _Code6 _Code7
Specify other events 22) Code	<input type="text" value="722"/>	
Specify other events 34) Code	<input type="text" value="3896"/>	
Specify other events 35) Code	<input type="text" value="3897"/>	
Specify other events 36) Code	<input type="text" value="3898"/>	
Specify other events 37) Code	<input type="text" value="3899"/>	
Specify other events 38) Code	<input type="text" value="3900"/>	

18. Here is a list of experiences that may have happened to your child. Has your child experienced any of these? *

No life experiences 700 ChildNoLifeExperiences

LifeExpChild_

Event Number	Age of child (in weeks)	Impact on child?	Impact on you?	Continuous Life Event?
<input type="text" value="585"/>	<input type="text" value="586"/>	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 587	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None 588	<input type="checkbox"/> Yes 1965
<input type="text"/>	<input type="text"/>	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="checkbox"/> Yes
<input type="text"/>	<input type="text"/>	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="radio"/> Good <input type="radio"/> Bad <input type="radio"/> Very Bad <input type="radio"/> None	<input type="checkbox"/> Yes

LifeExpChild_EventNum
_ChildAge _ImpactOnChild _ImpactOnYou ContinousLifeEvent1_1

Add

Specify other events 32) Code

ChildLifeExpOtherEventsCode1

3 month

Specify other events 33) Code

Specify other events 39) Code

Specify other events 40) Code

Specify other events 41) Code

Specify other events 42) Code

Specify other events 43) Code

ChildLife_OtherEvents_Code2

_Code3

_Code4

_Code5

_Code6

_Code7



51915

Subject ID

Tracking Form Symptoms of Celiac Disease before and after gluten-free diet

Office Use Only

Local Code:

Clinical Center:

Subject ID:

Visit Location Code:

Date Form completed:

 / /

(DD/MMM/YYYY - Example 01/JAN/2004)

Person Completing Form:

TEDDY Staff Code of Person Completing Form:



51915

Subject ID

This form should be completed for all children with Celiac Disease, regardless of whether the diagnosis occurred within or outside of the TEDDY study.

I. Gluten-free diet (GFD)

DIDCHILDRCEGFD

1. Did the child receive a GFD? Yes No Don't know

If **YES**, complete the following:

Start of gluten-free diet (DD/MMM/YYYY): / /

STARTGLUTENFREEDIETAGE

2. Did the child get GFD counselling from a dietician? Yes No Don't know

CHILGETDIETCOUNSELDIETI

3. Is the child currently on a **strict** GFD (free from wheat, rye, barley)?

Yes No Don't know **ISTHECHILDCURRENTLYSTRICTGFD**

4. Does the child's current diet contain oats? Yes No Don't know

CHILDCURRENTDIETCONTAINOATS

5. How often does the child consume food containing gluten (choose one option)? **CHILDCONSUMEFOODCONTAININGLUTEN**

- Never
- Less than once per month
- About once per month
- Several times a month
- Several times a week
- Nearly every day
- Don't know



51915

Subject ID

II. Has the child had or is currently having any of the following problems? (Mark all that apply)

Problems	Before the second positive tTGAb test in TEDDY <small>BEFORETHESEPOSITIVETTGABAGE</small>	After the second positive tTGAb test in TEDDY and before gluten-free diet was started <small>SECOSIBEFREGLUFREEAGE</small>	After 6 months of gluten-free diet <small>AFTER6MONTHSGLUTENFREEAGE</small>
Date symptom history collected :	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>NOSYMPTOMS</small> No symptoms	<small>NOSYMPTOMSFORCHILD_BEFORETHESECO</small> <input type="radio"/>	<small>NOSYMPTOMSFORCHILD_AFTERTHESECON</small> <input type="radio"/>	<small>NOSYMPTOMSFORCHILD_AFTERGLUTENFR</small> <input type="radio"/>
<small>CHRONICCONSTIPATION</small> Chronic constipation (i.e. <3 stools per week)	<small>CHRONICCONSTIPATION_BEFORETHESEC</small> <input type="radio"/>	<small>CHRONICCONSTIPATION_AFTERTHESECO</small> <input type="radio"/>	<small>CHRONICCONSTIPATION_AFTERGLUTENF</small> <input type="radio"/>
<small>FREQUENTLOOSESTOOLS</small> Frequent loose stools (i.e. ≥3 stools per day)	<small>FREQUENTLOOSESTOOLS_BEFORETHESECO</small> <input type="radio"/>	<small>FREQUENTLOOSESTOOLS_AFTERTHESECO</small> <input type="radio"/>	<small>FREQUENTLOOSESTOOLS_AFTERGLUTENF</small> <input type="radio"/>
<small>VOMITING2</small> Vomiting	<small>VOMITING_BEFORETHESECONDP</small> <input type="radio"/>	<small>VOMITING_AFTERTHESECONDP</small> <input type="radio"/>	<small>VOMITING_AFTERGLUTENFREEETWASS</small> <input type="radio"/>
Abdominal discomfort (i.e. being gassy, bloated, or complaining of pains) <small>ABDOMINALDISCOMFORT</small>	<small>ABDOMINALDISCOMFORT_BEFORETHESECO</small> <input type="radio"/>	<small>ABDOMINALDISCOMFORT_AFTERTHESECO</small> <input type="radio"/>	<small>ABDOMINALDISCOMFORT_AFTERGLUTENF</small> <input type="radio"/>
<small>POORGROWTH</small> Poor growth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<small>FATIGUE2</small> Fatigue	<small>FATIGUE_BEFORETHESECONDP</small> <input type="radio"/>	<small>FATIGUE_AFTERTHESECONDP</small> <input type="radio"/>	<small>FATIGUE_AFTERGLUTENFREEETWASS</small> <input type="radio"/>
<small>IRRITABILITY2</small> Irritability	<small>IRRITABILITY_BEFORETHESECONDP</small> <input type="radio"/>	<small>IRRITABILITY_AFTERTHESECONDP</small> <input type="radio"/>	<small>IRRITABILITY_AFTERGLUTENFREEETWASS</small> <input type="radio"/>
<small>DENTALENAMALDEFECTS</small> Dental enamel defects (Pits/ lines in teeth)	<small>DENTALENAMALDEFECTS_BEFORETHESECO</small> <input type="radio"/>	<small>DENTALENAMALDEFECTS_AFTERTHESECO</small> <input type="radio"/>	<small>DENTALENAMALDEFECTS_AFTERGLUTENF</small> <input type="radio"/>
<small>SKINIRRITATION</small> Skin irritation (e.g. itchy, red bumps, water blisters)	<small>SKINIRRITATION_BEFORETHESECONDP</small> <input type="radio"/>	<small>SKINIRRITATION_AFTERTHESECONDP</small> <input type="radio"/>	<small>SKINIRRITATION_AFTERGLUTENFREEETWASS</small> <input type="radio"/>
<small>NEUROLOGICALSYMPTOMS</small> Neurological symptoms (i.e. unsteady movements)	<small>NEUROLOGICALSYMPTOMS_BEFORETHESECO</small> <input type="radio"/>	<small>NEUROLOGICALSYMPTOMS_AFTERTHESECO</small> <input type="radio"/>	<small>NEUROLOGICALSYMPTOMS_AFTERGLUTENF</small> <input type="radio"/>
<small>ANEMIA2</small> Anemia (i.e. low iron in blood)	<small>ANEMIA_BEFORETHESECONDP</small> <input type="radio"/>	<small>ANEMIA_AFTERTHESECONDP</small> <input type="radio"/>	<small>ANEMIA_AFTERGLUTENFREEETWASS</small> <input type="radio"/>
Other <small>OTHER2</small> _____	<small>OTHER_BEFORETHESECONDP</small> <input type="radio"/>	<small>OTHER_AFTERTHESECONDP</small> <input type="radio"/>	<small>OTHER_AFTERGLUTENFREEETWASS</small> <input type="radio"/>
ICD-10 Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			