

Adverse Event Reporting Form

Initial Report AEREPORTTYPE

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

Adverse event occurrence date AEOCCURDTAGE	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 AEEXPECTED	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) AESELECTTERM	2189			<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
AESUPRAORDINATETERM AEASSOCIATIONS_DEATH AEASSOCIATIONS_DEVELOPMENTOFACON AEASSOCIATIONS_DEVELOPMENTOFAPER AEASSOCIATIONS_HOSPITALIZATIONOR AEASSOCIATIONS_LIFETHREATENING				
Patient status (at time of report): AEPATIENTOUTCOME	2181			*
Adverse event resolved date AERESOLVEDTAGE	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 AESTAFFCODE	2259			

Save Form

Submit for Review

Print

Close Window

Local use only

Subject ID

TEDDY Study



Annual Child Questionnaire

Local use only

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*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 ___ / ___ / ___

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.
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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.
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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.

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_9HOWDOYOUFEELABOUTBEINGINTHET

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

<input type="radio"/> I like it a lot.	<input type="radio"/> It is OK.	<input type="radio"/> I do not like it at all.
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_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.
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7. If you had a friend who was asked to be in a study like TEDDY would you tell them they should do it?

_11IFYOUHADAFRIENDWHOWASASKEDT

<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Maybe
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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). **_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.

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

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

<input type="radio"/> No	_7DOYOUODOTHINGSYOUTHINKMIGHTST
<input type="radio"/> Yes <i>If Yes, what do you do?</i> _____	
_7CHILDSTOPDIABETESCODE4_1	Code (office use only): _____
_7CHILDSTOPDIABETESCODE5_1	_7CHILDSTOPDIABETESCODE1_1
_7CHILDSTOPDIABETESCODE6_1	_7CHILDSTOPDIABETESCODE2_1
	_7CHILDSTOPDIABETESCODE3_1

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

<input type="radio"/> No	_8DOYOURPARENTSDOTHINGSTHEYTHI
<input type="radio"/> Yes <i>If Yes, what do they do?</i> _____	
_8PARENTSTOPDIABETESCODE1_1	Code (office use only): _____
_8PARENTSTOPDIABETESCODE2_1	_8PARENTSTOPDIABETESCODE4_1
_8PARENTSTOPDIABETESCODE3_1	_8PARENTSTOPDIABETESCODE5_1
	_8PARENTSTOPDIABETESCODE6_1
<input type="radio"/> I don't know	

11. 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.
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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

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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

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:** _____

TEDDY Study



Annual Child Questionnaire

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57135

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.
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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 _6IIFEELWORRIED	<input type="radio"/> Very worried	<input type="radio"/> Worried	<input type="radio"/> Not worried
b. I feel _6KIFEELFRIGHTENED	<input type="radio"/> Very frightened	<input type="radio"/> Frightened	<input type="radio"/> Not frightened
c. I feel _6LIFEELHAPPY	<input type="radio"/> Very happy	<input type="radio"/> Happy	<input type="radio"/> Not happy
d. I feel _6NIFEELGOOD	<input type="radio"/> Very good	<input type="radio"/> Good	<input type="radio"/> Not good
e. I feel _6OIFEELTROUBLED	<input type="radio"/> Very troubled	<input type="radio"/> Troubled	<input type="radio"/> Not troubled
f. I feel _6QIFEELNICE	<input type="radio"/> Very nice	<input type="radio"/> Nice	<input type="radio"/> Not nice

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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? _7DOYUODOTHINGSYOUTHINKMIGHTST

<input type="radio"/> No
<input type="radio"/> Yes <i>If Yes, what do you do?</i> <small>_7CHILDSTOPDIABETESYESCOMMENT</small> <hr/> <hr/> <hr/>
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> <small>_8PARENTSTOPDIABETESYESCOMMENT</small> <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

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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.

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57135

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)

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

Form Reviewed By: _____

TEDDY Staff Code of Person Reviewing Form:

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	*
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TEDDY Staff Code	* /	
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Form completed	Form Completed	<input type="radio"/> At home	<input type="radio"/> In clinic before blood draw	<input type="radio"/> In clinic after blood draw	<input type="radio"/> By phone
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Visit	VISIT	<input type="radio"/> 42 months (form was completed when child was between 36 months and 48 months of age)	<input type="radio"/> 54 months (form was completed when child was between 48 months plus one day and 60 months of age)	<input type="radio"/> 66 months (form was completed when child was between 60 months plus one day and 72 months of age)
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3455

3432

Date you completed this questionnaire: *

Your relationship to the child:
RELATIONSHIPTOCHILD
 3302

Mother
 Father
 Mother + Father completed form together
 Other Primary Caretaker
 Other **RELATIONSHIPTOTEDDYCHILDCODE**

Code 3426

3303	1. Aches or pains (without medical cause; do not include stomach or headaches) ACHESORPAINS	<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 ACTSTOOYOUNGFORAGE	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	25. Doesn't get along with other children see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3327
3305	3. Afraid to try new things AFRAIDTOTRYNEWTHINGS	<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 see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3328
3306	4. Avoids looking others in the eye see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	27. Doesn't seem to feel guilty after misbehaving see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3329
3307	5. Can't concentrate, can't pay see below attention for long see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	28. Doesn't want to go out of home see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3330
3308	6. Can't sit still, restless, or hyperactive see below	<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 see below	<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 see below	<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. see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3333
3311	9. Chews on things that aren't edible see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	32. Eats or drinks things that are not food - don't see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3334
3312	10. Clings to adults or too dependent see below	<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 see below	<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 see below	<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 see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	39. Headaches (without medical cause) see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3341
3319	17. Destroys his/her own things DESTROYSOWNTHINGS	<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 see below	<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) see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	42. Hurts animals or people without meaning to see below	<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 see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3345
3323	21. Disturbed by any change in routine see below	<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 see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	45. Nausea, feels sick (without medical cause) see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3347
3325	23. Doesn't answer when people talk to him/her see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	46. Nervous movements or twitching see below	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3348

3306.4 AVOIDSLOOKINGOTHERSINTHEEYE
 3307.5 CANTPAYATTENTIONFORLONG
 3308.6 CANTSITSTILLHYPERACTIVE
 3309.7 CANTSTANDTHINGSOUTOFPLACE
 3310.8 CANTSTANDWAITINGIMPATIENT
 3311.9 CHEWSONINEDIBLETHINGS
 3312.10 CLINGSTOADULTSTOODEPENDENT
 3314.12 CONSTIPATEDDOESNTMOVEBOWELSWHE
 3318.16 DEMANDSMUSTBEMETIMMEDIATELY
 3320.18 DESTROYSTHINGSBELONGINGTOFAMIL
 3321.19 DIARRHEALOOSEBOWELSWHENNOTSICK
 3323.21 DISTURBEDBYANYCHANGEINROUTINE
 3324.22 DOESNTWANTTOSLEEPALONE
 3325.23 DOESNTTALKWHENPEOPLETALKTOCHIL

3327.25 DOESNTGETALONGWITHOTHERCHILDR
 3328.26 DOESNTKNOWHOWTOHAVEFUNLITTEAD
 3329.27 DOESNTSEEMGUILTYAFTERMISBEHAVI
 3330.28 DOESNTWANTTOGOOOUTOFHOME
 3333.31 EATSDRINKSTHINGSTHATARENOTFOOD
 3334.32 FEARSCERTAINANIMALSSITUATIONSO
 3336.34 GETSHURTALOTACCIDENTPRONE
 3339.37 GETSTOOUPSETWHENSEPARATEDFROM
 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 SLEEPSLESSTHANMOSTKIDSNIGHTORD	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3376
3350	48. Nightmares NIGHTMARES	<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 OVEREATING	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	76. Speech problem SPEECHPROBLEM	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3378
3352	50. Overtired OVERTIRED	<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 <i>see below</i> 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)	<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 PHYSICALLYATTACKSPEOPLE	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	80. Strange behavior STRANGEBEHAVIOR	<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>see below</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 SULKSALOT	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3385
3359	57. Problems with eyes without medical condition)	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	84. Talks or cries out in sleep TALKSORCRIESOUTINSLEEP	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3386
3360	58. Punishment doesn't change <i>see below</i> 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 <i>see below</i> to another	<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>see below</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	87. Too fearful or anxious TOOFEARFULORANXIOUS	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3389
3363	61. Refuses to eat	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	88. Uncooperative UNCOOPERATIVE	<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 UNHAPPYSADORDEPRESSED	<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 UNUSUALLYLOUD	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3393
3367	65. Resists toilet training RESISTSTOILETRAINING	<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 SCREAMSALOT	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	93. Vomiting, throwing up (without medical cause)	<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 WAKESUPOFTENATNIGHT	<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 WANDERSAWAY	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3397
3371	69. Selfish or won't share SELFISHORWONTSHARE	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	96. Wants a lot of attention WANTSALOTOFATTENTION	<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 WHINING	<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 WORRIES	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2	3401
3375	73. Too shy or timid TOOSHYORTIMID	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2			

3349.47 NERVOUSHIGHSTRUNGORTENSE
 3353.51 SHOWSPANICFORNOGOODREASON
 3354.52 PAINFULBOWELMOVEMENTSWITHOUTME
 3356.54 PICKSNOSESKINOROTHERBODYPART
 3357.55 PLAYSWITHOWNSEXPARTSTOOMUCH
 3358.56 POORLYCOORDINATEDORCLUMSY
 3359.57 PROBLEMSWITHEYESWITHOUTMEDCOND
 3360.58 PUNISHMENTDOESNTCHANGEBEHAVIOR
 3361.59 QUICKLYSHIFTSFROMONEACTIVITYTO
 3362.60 RASHESOROTHERSKINPROBLEMSWITHO
 3364.62 REFUSESTOPLAYACTIVEGAMES
 3365.63 REPEATEDLYROCKSHEADORBODY
 3366.64 RESISTSGOINGTOBEDATNIGHT
 3369.67 SEEMSUNRESPONSIVETOAFFECTION
 3370.68 SELFCONCIOUS EASILYEMBARRASSED
 3372.70 SHOWSLITTLEAFFECTIONTOWARDPEOP
 3373.71 SHOWSLITTLEINTERESTINTHINGSARO
 3374.72 SHOWSTOOLITTLEFEAROFGETTINGHUR

3377.75 SMEARSORPLAYSWITHBOWELMOVEMENT
 3379.77 STARESINTOSPACEORPREOCCUPIED
 3380.78 STOMACHACHESORCRAMPSWITHOUTMED
 3381.79 RAPIDSHIFTBETWEENSADNESSANDEXC
 3383.81 STUBBORNSULLENORIRRITABLE
 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):

___/___/_____
INITIALLTTGABPOSITIVEAGE

Age of the child: ___ years ___ months

AGECHILDINITTTGABPOSITIVEYEARS AGECHILDINITTTGABPOSITIMON

Result (Units) for initial TEDDY tTGAb positive sample:

RESINITIALTTGABPOSITIVE

___ . ___ ___ positive value (for example 0.030) RESINITTTGABPOSITIVE negative value (for example -0.030)Laboratory: Bristol Denver

LABINITTTGABPOSITIVE

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

___/___/_____
CONFIRMTTGABPOSITIVEAGE

Age of the child: ___ years ___ months

AGECHILDCONFIRMTTGABPOSITIVEYEAR AGECHILDCONFIRMTTGABPOSITIMON

Result (Units) for confirmatory TEDDY tTGAb positive sample:

RESCONFIRMTTGABPOSITIVE

___ . ___ ___ positive value (for example 0.030) RESULTCONFIRMTTGABPOSITIVE negative value (for example -0.030)Laboratory: Bristol Denver

LABCONFIRMTTGABPOSITIVESAMPLE

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

___/___/_____
ADDCONFIRMTTGABPOSITIVEAGE

Age of the child: ___ years ___ months

AGEINYEARADDCONFIRMTTGABPOSITIVE AGEMONTHSADDCONFIRMTTGABPOSITIVE

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

RESADDCONFIRMTTGABPOSITIVE

___ . ___ ___ positive value (for example 0.030) RESULTADDCONFIRMTTGABPOSITIVE negative value (for example -0.030)Laboratory: Bristol Denver

LABADDCONFIRMTTGABPOSITIVE

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

CELIACCONFIRMBYINTESTINALBIOPSY

If YES, complete the following:

Date of biopsy (DD/MMM/YYYY): ___/___/_____
CELIACCONFIRMINTESTINALBIOPSYAGE

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 |

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
- WHYBIOPSYNOTPERFORME_THEPEDIATRI
 WHYREFUSEDBIOPSY_DOESNTWANTCHILD
 WHYREFUSEDBIOPSY_FAMILYHISTORYOF
 WHYREFUSEDBIOPSY_NOHEALTHINSURAN
 WHYREFUSEDBIOPSY_WANTTOWAITANDSE
 WHYREFUSEDBIOPSY_WANTTOWAITUNTIL

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

Subject ID: _____

i.e. being gassy, bloated, or complaining of pains			
Poor weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short stature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental enamel defects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin manifestations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<hr/>			
ICD-10 Code			

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
SUB_STATUS_TYPE_CDWho is declining the participation? Parent Child Both**NEW_SUB_STATUS_CD**

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**REASON_CHANGE_SUB_STAT_CD**

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

Save

Save & Print

Clear

Close

SubjectID

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.

Local Use Only

SubjectID

Date you completed this questionnaire:

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

(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 IFEELHUNGRY	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
2. I feel thirsty IFEELTHIRSTY	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
3. I have to go to the bathroom too often IHAVETOGO BATHROOMTOO OFTEN	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
4. I have tummy aches IHAVETUMMYACHES	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
5. I have headaches IHAVEHEADACHES	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
6. I feel like I need to throw up IFEELLIKEINEEDTOTHROWUP	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
7. I go "low" IGOLOW	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
8. I go "high" IGOHIGH	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
9. I feel tired IFEELTIRED	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
10. I get shaky IGETSHAKY	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
11. I get sweaty IGETSWEATY	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
12. I feel dizzy IFEELDIZZY	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
13. I feel weak IFEELWEAK	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
14. I have trouble sleeping IHAVETROUBLESLEEPIN	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
15. I get cranky or grumpy IGETCRANKYORGRUMPY	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

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

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

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	Some-times	Often	Almost Always
1. It is hard for me to take blood glucose tests HARDTOTAKEBLOODGLUCOSETESTS	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
2. It is hard for me to take insulin shots HARDTOTAKEINSULINSHOTS	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
3. It is hard for me to play or do sports HARDTOPLAYORDOSPORTS	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
4. It is hard for me to keep track of carbohydrates HARDTOKEEPTRACKOFCARBS	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
5. It is hard for me to carry a fast-acting carbohydrate HARDTOCARRYFASTACTINGCARB	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
6. It is hard for me to snack when I go "low" HARDTOSNACKWHENLOW	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

Local Use Only

SubjectID

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" <i>IWORRYABOUTGOINGLOW</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
2. I worry about going "high" <i>IWORRYABOUTGOINGHIGH</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

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 <i>HARDTOTELLDOCTORSHOWIFEEL</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
2. It is hard for me to ask the doctors and nurses questions <i>HARDTOASKDOCTORSQUESTIONS</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
3. It is hard for me to explain my illness to other people <i>HARDTOEXPLAINILLNESS</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
4. I am embarrassed about having diabetes <i>EMBARRASSEDABOUTHAVINGDIABETES</i>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4



52578

*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

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:

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

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

Person Completing Form: _____

TEDDY Staff Code of Person Completing Form: INTERVIEWER_ID

PERSONSINTERVIEWED_MOTHER

PERSONSINTERVIEWED_FATHER

PERSONSINTERVIEWED_OTHERPRIMARYC

Person(s) Interviewed:

 Mother Father Other Primary CaretakerPERSONSINTERVIEWED_OTHER Other, specify

Code:

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

PERSONINTERVIEWEDOTHERCODE



12010

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:

--	--	--

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

		.		%
--	--	---	--	---

Local Use Only



12010

SubjectID

C. INSULIN

1. Daily insulin routine (check one):

INSULINDAILYROUTINE

- No insulin
- 1-2 Injections per day
- 3+ Injections per day (MDI)
- Insulin Pump (CSII)

2. Average units/day of short acting insulin (average over 3 day period):
(e.g. Regular, Apidra, LisPro, Novolog, Humalog, bolus doses if on pump)

INSULINAVESHORTACTINGINSULIN

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

3. Average units/day of intermediate/long acting insulin (average over 3 day period):

(e.g. Lantus, NPH, Lente, Levemir, Ultralente, basal rate if on pump)

INSULINAVEINTLONGACTINGINSULIN

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

4. What type(s) of insulin does your child use?

- INSULINNTYPE_LANTUSGLARGINE** Lantus (glargine)
- INSULINTYPE_LEVEMIRDETEMIR** Levemir (detemir)
- INSULINTYPE_NOVALOGASPART** Novolog (aspart)
- INSULINTYPE_HUMALOGLISPRO** Humalog (lispro)
- INSULINTYPE_NOVOLINNPH** Novolin N (NPH)
- INSULINTYPE_HUMULINNPH** Humulin N (NPH)
- INSULINTYPE_7525MIX** 75/25 mix
- INSULINTYPE_OTHERPLEASESPECIFY** Other (please specify)

DTYPEINSULINOTHERCODE Code:

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

D. HYPOGLYCEMIA

Record information from any records or history by the participant since the last visit.

1. Has your child experienced any severe hypoglycemic events (loss of consciousness, seizure, or assistance required from another person due to an altered state or consciousness) since the last visit? **HYPOGLYCEMIASEVEREEVENTS**

 Yes NoIf YES, **HYPOGLYCEMIASEVEREEVENTSHOWMAN**

a. How many severe hypoglycemic events have occurred since the last visit?

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

2. How many low blood glucose levels (less than 60 mg/dl or less than 3.3mmol/L) has your child had on average per week since the last visit?

LOWBLOODGLUCOSELEVELS

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

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"/> <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**

- 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**

- No reason given **REF_CAT1**
- Unavailable - moving out of the area **REF_CAT2**
- 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**
- 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**
- 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

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	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	Age at diagnosis 1263 or Year of diagnosis 1264 <input type="checkbox"/> Unknown 3832	PaternalGrandMotherTakeInsulinShot 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	Age at diagnosis 1274 or Year of diagnosis 1275 <input type="checkbox"/> Unknown 3835	PaternalGrandFatherTakenInsulinShot 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 ChildsAuntUncleBirthYr1 ChildAuntUncleBirthYrUnknown1	1278 <input type="checkbox"/> Unknown 3842	<input type="radio"/> Male <input type="radio"/> Female 1279 AuntUncleSex1	1282 → AuntUncleAgeDeath1 Age at death 1280 or Year of death 1281 <input type="checkbox"/> Unknown 3843 ChildAuntUncleAgeYrDeathUnkwn3	<input type="checkbox"/> none or unknown ICD - 10 (Office use only) 1283 <input type="checkbox"/> ICD - 10 (Office use only) 1284 ICD - 10 Codes 2152 Add	1285 <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	AuntUncleDiabetesDiagAge1 AuntUncleDiabetesDiagYr1 Age at diagnosis 1287 or Year of diagnosis 1288 <input type="checkbox"/> Unknown 3844	1289 <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	1291 <input type="checkbox"/> Unknown 3836	<input type="radio"/> Male <input type="radio"/> Female 1292 AuntUncleSex3	1295 → AuntUncleAgeDeath2 Age at death 1293 or Year of death 1294 <input type="checkbox"/> Unknown 3837	<input type="checkbox"/> none or unknown ICD - 10 (Office use only) 1296 <input type="checkbox"/> ICD - 10 (Office use only) 1297	1298 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleDiabetic3	1299 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown AuntUncleDiabetesType3	Age at diagnosis 1300 or Year of diagnosis 1301 <input type="checkbox"/> Unknown 3838	1302 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleTakenInsulin2
1303 <input type="radio"/> Mother's sibling <input type="radio"/> Father's sibling ChildsAuntUncle3	1304 <input type="checkbox"/> Unknown 3839	<input type="radio"/> Male <input type="radio"/> Female 1305	1308 → AuntUncleAgeDeath3 AuntUncleDeathYr3 Age at death 1306 or Year of death 1307 <input type="checkbox"/> Unknown 3840	<input type="checkbox"/> none or unknown ICD - 10 (Office use only) 1309 <input type="checkbox"/> ICD - 10 (Office use only) 1310	1312 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleDiabetic3	1312 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown AuntUncleDiabetesType3	Age at diagnosis 1313 or Year of diagnosis 1314 <input type="checkbox"/> Unknown 3841	1315 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown AuntUncleTakenInsulin3

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 → 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"/> 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 → 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"/> 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 → 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"/> 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="checkbox"/> <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=""/> <input type="checkbox"/> Unknown	<input type="radio"/> Male <input type="radio"/> Female	<input type="text" value=""/> <input type="text" value=""/> <input type="checkbox"/> Unknown	<input type="checkbox"/> <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 Add SiblingAutoImmDiseCode1 Sibling1AutoImmDiseCode2 SiblingsAutoimmuneDiseaseIC1_1	1403 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown SiblingDiabetic1	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	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	1435 <input type="checkbox"/> Unknown 3872	1436 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1437 or Year of death 1438 <input type="checkbox"/> Unknown 3873	<input type="checkbox"/> none or unknown 1439 ICD-10 (Office use only) 1440 ICD-10 (Office use only) 1441	1442 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1443 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1444 or Year of diagnosis 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	1448 <input type="checkbox"/> Unknown 3875	1449 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1450 or Year of death 1451 <input type="checkbox"/> Unknown 3876	<input type="checkbox"/> none or unknown 1452 ICD-10 (Office use only) 1453 ICD-10 (Office use only) 1454	1455 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1456 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1457 or Year of diagnosis 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	1461 <input type="checkbox"/> Unknown 3878	1462 <input type="radio"/> Male <input type="radio"/> Female	Age at death 1463 or Year of death 1464 <input type="checkbox"/> Unknown 3879	<input type="checkbox"/> none or unknown 1465 ICD-10 (Office use only) 1466 ICD-10 (Office use only) 1467	1468 <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	1469 <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Gestational <input type="radio"/> Unknown	Age at diagnosis 1470 or Year of diagnosis 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	
<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
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: RELATION_CD

(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) 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	GENDER_CD
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:	MULTIPLE_TYPE_CD		
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
	HAVE_DIABETES_CD		
a) If yes, what is the diabetes type?	<input type="radio"/> Type 1 Diabetes		
	<input type="radio"/> Type 2 Diabetes	DIABETES_TYPE_CD	
	<input type="radio"/> Gestational		
	<input type="radio"/> Unknown		
b) If yes, what was his/her age at diagnosis or year of diagnosis?			
Age:	<input type="text"/> DIABETES_AGE_DXOR	Year:	<input type="text"/> DIABETES_YEAR_DX
c) If yes, has insulin been started?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	INSULIN_STARTED_CD		
Date of starting insulin therapy:	<input type="text"/>	<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

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: **107773**

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

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	53	54	55	*	Visit Location Code		*
TEDDY Staff Code				*			

1. Date you completed this questionnaire:

56	57	58	*
----	----	----	---

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

monthFormReviewed dayFormReviewed YearFormReviewed

- 18 **2. Compared to other children, do you think your child's risk for developing diabetes is:** ChildsRiskForDiabetes
(Mark one answer) _CHILDSRISKFORDIABETES
- 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)

- The child will develop diabetes in the near future BabysFutureDoYouThink
- 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)

- 20 a. Not at all calm Somewhat calm Moderately calm Very calm BabysRiskDiabetesFeelCalm
- 21 b. Not at all worried Somewhat worried Moderately worried Very worried BabysRiskDiabetesFeelWorried
- 22 c. Not at all relaxed Somewhat relaxed Moderately relaxed Very relaxed BabysRiskDiabetesFeelRelaxed
- 23 d. Not at all tense Somewhat tense Moderately tense Very tense BabysRiskDiabetesFeelTense
- 24 e. Not at all at-ease Somewhat at-ease Moderately at-ease Very at-ease BabysRiskDiabetesFeelAtEase
- 25 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?**

- No Yes Maybe RecommendGeneticTestFriends

Save

Save & Print

Clear

Close



49511

TEDDY Study



First Child Questionnaire

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49511

Local Use Only

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)

_1DIDYOUREADTHEBOOK

<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)

_2HOWWASTHEBOOK

<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)

_3DIDTHEBOOKHELPLYOUUNDERSTANDW

<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

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 <small>_6IIFEELWORRIED</small>	<input type="radio"/> Not worried
b. I feel	<input type="radio"/> Very frightened	<input type="radio"/> Frightened <small>_6KIFEELFRIGHTENED</small>	<input type="radio"/> Not frightened
c. I feel	<input type="radio"/> Very happy	<input type="radio"/> Happy <small>_6LIFEELHAPPY</small>	<input type="radio"/> Not happy
d. I feel	<input type="radio"/> Very good	<input type="radio"/> Good <small>_6NIFEELGOOD</small>	<input type="radio"/> Not good
e. I feel	<input type="radio"/> Very troubled	<input type="radio"/> Troubled <small>_6OIFEELTROUBLED</small>	<input type="radio"/> Not troubled
f. I feel	<input type="radio"/> Very nice	<input type="radio"/> Nice <small>_6QIFEELNICE</small>	<input type="radio"/> Not nice

Local Use Only



49511

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?

_7DOYOUODTHINGSYOUTHINKMIGHTST

<input type="radio"/> No
<input type="radio"/> Yes <i>If Yes, what do you do?</i> <u>_7CHILDSTOPDIABETESCODE1_1</u> <u>_7CHILDSTOPDIABETESCODE2_1</u> <u>_7CHILDSTOPDIABETESCODE3_1</u>
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> <u>_8PARENTSTOPDIABETESCODE1_1</u> <u>_8PARENTSTOPDIABETESCODE2_1</u> <u>_8PARENTSTOPDIABETESCODE3_1</u>
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

Local Use Only

49511

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.

Local Use Only

49511

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"/> *EVENT_AGE	Visit Location Code	<input type="text"/> *
Visit Months	<input type="text"/> months OR <input type="text"/> years	TEDDY Staff Code of Interviewer	<input type="text"/> *
OR	4176 months OR 4177 years		
Visit Years	VisitMonths Visityears		INTERVIEWER_ID

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 *childconsumefoodcontainingglut*
- Less than once per month
- About once per month
- Several times a month
- Several times a week
- Nearly every day
- Don't know

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	
Date Form was Reviewed	2068 2069 2070 *	Visit Location Code	*
TEDDY Staff Code	*		
Form Status	2166		
	<input checked="" type="radio"/> Sent out but not returned EXITQUESTIONNAIREFORMSTATUS <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		

Page: 1 of 3

Go to page:

1. Date you completed this questionnaire:		<input type="text"/>	<input type="text"/>	<input type="text"/>	*
2. What is your relationship to the TEDDY child? 2036					
RELATIONSHIPTOCHILD_MOTHER RELATIONSHIPTOCHILD_OTHERPRIMARY					
<input checked="" type="checkbox"/> Mother	<input checked="" type="checkbox"/> Father	<input checked="" type="checkbox"/> Other Primary Caretaker	<input checked="" type="checkbox"/> Other		
Code	<input type="text" value="2071"/>	RELATIONSHIPTOCHILD_FATHER			
3. Who decided that this child would be in the TEDDY study? 2037					
PERSONDECIDINGTEDDYC_IDECIDED PERSONDECIDINGTEDDYC_MYSPOUSEOTH					
<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?)		
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?					
ANYONENOTWANTINGCHILDINTEDDY					
<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 NOTWANTINGCHILDINTEDDYCODE					
<input checked="" type="checkbox"/> I did not want the child in the study	WHODIDNOTWANTCHILDIN_IDIDNOTWANT				
<input checked="" type="checkbox"/> My spouse did not want the child in the study	WHODIDNOTWANTCHILDIN_MYSPOUSEDID				
<input checked="" type="checkbox"/> The child's grandparents did not want the child in the study	WHODIDNOTWANTCHILDIN_THECHILDSGR				
<input checked="" type="checkbox"/> Other(who?)	Otherwho	WHODIDNOTWANTCHILDIN_OTHERWHO			
Other	<input type="text" value="2118"/>	Code	<input type="text" value="2073"/>		
5. For your family, was the decision for this child to be in TEDDY: 2040 DIFFICULTYFORFAMILYCHILDINTEDD					
<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	
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	PARTOFSTUDYCOMINGTOCENTER		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Having blood drawn from the child 2042	PARTOFSTUDYHAVINGCHILDSBLOOD		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Keeping records of what the child eats 2043	PARTOFSTUDYRECORDSOFCHELDSFOOD		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Keeping the child's records in the TEDDY book 2044	PARTOFSTUDYRECORDSINTEDDYBOOK		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Sending in the child's stool or poop samples 2045	PARTSTUDYSENDINGCHILDSSTOOLSAM		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Filling out questionnaires 2046	PARTOFSTUDYFILLINGQUESTIONNAIR		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Spending time on TEDDY tasks 2081	PARTOFSTUDYSPENDINGTIMEONTEDDY		<input checked="" type="radio"/> Very difficult	<input type="radio"/> A little difficult	<input type="radio"/> Not difficult at all
Something else - tell us 2048	<input type="text" value="2048"/>		2047		
Code	<input type="text" value="2077"/>	<input checked="" type="radio"/> Very difficult <input type="radio"/> A little difficult <input type="radio"/> Not difficult at all			
PARTOFSTUDYTELLUSSOMETHINGELSE					

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 WORSTPARTOFSTUDY

- 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
- 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 Code WORSTPARTOFSTUDYOTHERCODE

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

- 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
- 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 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?** ANYTHINGTOSTOPCHILDFROMDIABETE

No Yes

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 THINGSDIDTOSTOPCHILD_INTRODUCED1

Introduced solid foods, such as baby food, table food, or cereal, later than you had planned THINGSDIDTOSTOPCHILD_INTRODUCED2

Breastfed child longer THINGSDIDTOSTOPCHILD_BREASTFEDTH

Delayed introduction of cow's milk or infant formula based on cow's milk THINGSDIDTOSTOPCHILD_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_AVOIDEDORL1

Avoided or limited child's intake of soda or sweet drinks THINGSDIDTOSTOPCHILD_AVOIDEDORL2

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

Gave child herbal supplements THINGSDIDTOSTOPCHILD_GAVECHILDHE

Gave child nicotinamide

Tried extra hard to protect child from germs THINGSDIDTOSTOPCHILD_TRIEEXTRAH

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 ANYTHINGTOSTOPCHILDDIABCODE

Other Code

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?** RECOMMENDEDDYSTUDYTOFRIEND

No Yes Maybe

3295 **14. What was the main reason for leaving the TEDDY study?** REASONFORLEAVINGTEDDYSTUDY

My child got diabetes

My child was found not to have the high risk genes

Moving out of the TEDDY area

Other (please do not give more than two reasons)

Don't want to answer

Other Code

Other Code

Other Codes

OTHERREASONFORLEAVINGSTUDY
OTHERREASONFORLEAVINGSTUDY2
OTHERREASONFORLEAVINGSTUDYCODE
OTHERREASONFORLEAVINGSTUDYCODE2
OTHERDYNCODEREASONLEAVESTUD1_1

2119 **15. May we contact you in the future?** CONTACTINFUTURE

No Yes

2066 **16. Below, please tell us anything else you would like us to know about your experience with TEDDY.**

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:

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

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

Person Completing Form: _____

TEDDY Staff Code:

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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

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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)

<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.
<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

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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: OTHDIABETESMEDSPEC1

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
 OTHDIABETESMEDTIME2IN

		:		
Hour			Minute	

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

3) OTHDIABETESMEDSPEC3

Code:

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

OTHDIABETESMEDCODE3

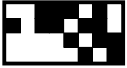
Time medication #3 was taken:

OTHDIABETESMEDTIME3R
 OTHDIABETESMEDTIME3IN

		:		
Hour			Minute	

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

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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



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SubjectID

Sample and Meal Timepoints

Time

Missed Sample

<p>-10 (baseline) minutes c-peptide sample</p> <p>BASELINECPEPSAMPLEHR BASELINECPEPSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p>BASELINECPEPSAMPLEMISSED</p>
<p>-10 (baseline) minutes glucose sample</p> <p>BASELINEGLUSAMPLEHR BASELINEGLUSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p>BASELINEGLUSAMPLEMISSED</p>
<p>0 minutes c-peptide sample</p> <p>_0MINCPEPSAMPLEHR _0MINCPEPSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p>_0MINCPEPSAMPLEMISSED</p>
<p>0 minutes glucose sample</p> <p>_0MINGLUSAMPLEHR _0MINGLUSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p>_0MINGLUSAMPLEMISSED</p>
<p>Start time of meal administration</p> <p>Note: Meal should be consumed within 5 minutes</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p>STARTMEALHR STARTMEALMIN</p>
<p>If meal consumption time >5 minutes from "0" minutes - indicate time consumed 75% of meal</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p>CONSUMED75PCTMEALHR CONSUMED75PCTMEALMIN</p>

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15 minutes c-peptide sample _15MINCPEPSAMPLEHR _15MINCPEPSAMPLEMIN	<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 _15MINCPEPSAMPLEMISSED
15 minutes glucose sample _15MINGLUSAMPLEHR _15MINGLUSAMPLEMIN	<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 _15MINGLUSAMPLEMISSED
30 minutes c-peptide sample _30MINCPEPSAMPLEHR _30MINCPEPSAMPLEMIN	<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 _30MINCPEPSAMPLEMISSED
30 minutes glucose sample _30MINGLUSAMPLEHR _30MINGLUSAMPLEMIN	<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 _30MINGLUSAMPLEMISSED
60 minutes c-peptide sample _60MINCPEPSAMPLEHR _60MINCPEPSAMPLEMIN	<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 _60MINCPEPSAMPLEMISSED
60 minutes glucose sample _60MINGLUSAMPLEHR _60MINGLUSAMPLEMIN	<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 _60MINGLUSAMPLEMISSED

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<p>90 minutes c-peptide sample</p> <p><u> </u> _90MINCPEPSAMPLEHR <u> </u> _90MINCPEPSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p><u> </u> _90MINCPEPSAMPLEMISSED</p>
<p>90 minutes glucose sample</p> <p><u> </u> _90MINGLUSAMPLEHR <u> </u> _90MINGLUSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p><u> </u> _90MINGLUSAMPLEMISSED</p>
<p>120 minutes c-peptide sample</p> <p><u> </u> _120MINCPEPSAMPLEHR <u> </u> _120MINCPEPSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p><u> </u> _120MINCPEPSAMPLEMISSED</p>
<p>120 minutes glucose sample</p> <p><u> </u> _120MINGLUSAMPLEHR <u> </u> _120MINGLUSAMPLEMIN</p>	<p><input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/></p> <p>Hour Minute</p> <p>(Record time in Universal Time - e.g. 2:00 pm would be recorded as 14:00)</p>	<p><input type="radio"/> Missed sample</p> <p><u> </u> _120MINGLUSAMPLEMISSED</p>

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9a. Blood glucose reading at 120 minute timepoint

 mg/dL OR _120MINTMEPOINTMGDL

 . mmol/L _120MINTMEPOINTMMOLL
For Sweden only:

Hemocue 1:

 . mmol/L _120MINTMEPOINTHEMOCUE1

Hemocue 2:

 . mmol/L _120MINTMEPOINTHEMOCUE2

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.

Local Use Only



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

- No
 Yes

If YES, mark all that apply:

- Abdominal pain SYMPTOMSOSBSEVWHICH_ABDOMINALPAI
- Diaphoresis (excessive sweating) SYMPTOMSOSBSEVWHICH_DIAPHORESISE
- Lightheadedness SYMPTOMSOSBSEVWHICH_LIGHTHEADEDN
- Nausea and or vomiting SYMPTOMSOSBSEVWHICH_NAUSEAANDORV
- Seizure
- Tremors or trembling SYMPTOMSOSBSEVWHICH_TREMORSORTRE
- Loss of consciousness due to low blood glucose
- Loss of consciousness due to phlebotomy (fainting)
- Blood glucose is < 45 mg/dL or 2.5 mmol/L
- Blood glucose is > 300 mg/dL or 16.7 mmol/L with ketones >1.5 mmol/L
SYMPTOMSOSBSEVWHICH_BLOODGLUCOS2
- Blood glucose is > 500 mg/dL or 27.8 mmol/L with or without ketones
SYMPTOMSOSBSEVWHICH_BLOODGLUCOS3
- Other (specify):

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:

109	110	111	*
-----	-----	-----	---

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 ILLCONDITIONFLUBADCOLD	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
118	b. Sore throat, tonsillitis, strep throat ILLCONDITIONSORETHROAT	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
119	c. Bronchitis ILLCONDITIONBRONCHITIS	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
120	d. Genital herpes ILLCONDITIONGENITALHERPES	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
121	e. Cold sores ILLCONDITIONCOLDSCORE	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
122	f. Pneumonia ILLCONDITIONPNEUMONIA	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
123	g. Sinus infection ILLCONDITIONSINUS	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
124	h. Ear infection ILLCONDITIONEARINFECTION	<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 ILLCONDITIONSKININFECTION	<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 ILLCONDITIONOTHERINFECTIONFEVE	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
129	m. Yellow skin (jaundice) ILLCONDITIONYELLOWSKINJAUNDICE	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
130	n. High blood pressure ILLCONDITIONHIGHBP	<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) ILLCONDITIONANEMIA	<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) ILLCONDITIONMORNINGSICKNESS	<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"/>	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
	More ICD-10 Codes <input type="text" value="188"/> <input type="text"/> <input type="text"/>	ILLNESSCONDITIONOTHER ILLNESSCONDITIONICD10CODE ILLCONDITIONPREGOTHERCODES1_1 ILLCONDITIONPREGOTHERCODES2_1 ILLCONDITIONPREGOTHERCODES3_1 ILLCONDITIONPREGOTHERCODES4_1
	<input type="button" value="Add"/>	

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) See below	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
141	e. Abruptio placenta, or abruption (placenta seperated from uterine wall) See below	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
142	f. Premature rupture of the members (your water broke before labor started) See below	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know
143	g. Prolonged labor (labor for more than 24 hours) See below	<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) See below	<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) See below	<input checked="" type="checkbox"/> Diet <input checked="" type="checkbox"/> Pills <input checked="" type="checkbox"/> Insulin <input checked="" type="checkbox"/> No treatment See below
	c. What was your average or last HbA1c during pregnancy? See below	Average <input type="text" value="149"/> % <input checked="" type="checkbox"/> Don't know Last <input type="text" value="150"/> % 151
152	d. Have you had gestational diabetes during previous pregnancies? PREVPREGGESTATIONALDIABETES	<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

3d. PLACENTAPRECEDEDTHEBABY
3e. CONDITIONPLACENTAABRUPTION
3f. MEMBRANEPREMATURERUPTURE
3g. CONDITIONPROLONGEDLABOR
3i. CONDITIONPREMATURELABOR

4b.GESTATIONALDIABETEST_DIET
GESTATIONALDIABETEST_PILLS
GESTATIONALDIABETEST_INSULIN
GESTATIONALDIABETEST_NOTTREATMENT

4c. AVGHBA1CGESTATIONAL
LASTHBA1CGESTATIONALDURINGPREG
AVGLASTHBA1CDONTKNOWGESTATIONA

153	5. Do you have Type 1 or Type 2 diabetes?* DIABETESTYPE	<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"/> AGEWHENDIAGDIABETES
155	b. How was your diabetes treated before pregnancy? (Mark all that apply) See below	<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) See below	<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) See below	<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? DIABETESLASTHBA1C	<input type="text" value="158"/> % <input checked="" type="checkbox"/> Don't know DIABETESLASTHBA1CDONTKNOW
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 RHNEGATIVEBLOODTYPEYESNO
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 IFRHNEGATIVEGOTSHOTINJECTION
162	b. If you did get a shot or injection, when did you get the shot or injection? See below	<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 VACCINESPREGTIMEYESNO
	If Yes, please mark which vaccines and during which trimester:	
164	Flu Shot FLUSHOTWHICHTRIMESTER	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester
165	Tetanus TETANUSSHOTWHICHTRIMESTER	<input type="checkbox"/> First Trimester <input type="checkbox"/> Second Trimester <input type="checkbox"/> Third Trimester
166	Other, What? 168 <input type="text"/> See below	<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
	<input type="text" value="1941"/>	<input checked="" type="checkbox"/> First Trimester <input checked="" type="checkbox"/> Second Trimester <input checked="" type="checkbox"/> Third Trimester See below
	<input type="text"/>	

5b. DIABETESTREATMETHODB_DIET
 DIABETESTREATMETHODB_PILLS
 DIABETESTREATMETHODB_INSULIN
 DIABETESTREATMETHODB_NOTREATMENT

OTHERVACCCODE1_1
 OTHERVACCTRIMEST_FIRSTTRIMES1_1
 OTHERVACCTRIMEST_SECONDTRIME1_1
 OTHERVACCTRIMEST_THIRDTRIMES1_1
 OTHERVACCCODE2_1
 OTHERVACCTRIMEST_FIRSTTRIMES2_1
 OTHERVACCTRIMEST_THIRDTRIMES2_1
 OTHERVACCCODE3_1
 OTHERVACCTRIMEST_FIRSTTRIMES3_1

5c. DIABETESTREATMETHODD_DIET
 DIABETESTREATMETHODD_PILLS
 DIABETESTREATMETHODD_INSULIN
 DIABETESTREATMETHODD_NOTREATMENT

5d. DIABETESTREATMETHODN_DIET
 DIABETESTREATMETHODN_PILLS
 DIABETESTREATMETHODN_INSULIN
 DIABETESTREATMETHODN_NOTREATMENT

6b. SHOTINJECTIONPERIOD_BEFOREPREGNA
 SHOTINJECTIONPERIOD_DURINGPREGNA
 SHOTINJECTIONPERIOD_AFTERDELIVER

7. OTHERSHOTINJECTIONCODE

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
		ANTIBIOTICNAME2_1
		ANTIBIOTICNAME3_1
		ANTIBIOTICNAME4_1
		ANTIBIOTICNAME5_1
		DURINGPREGANTIBIOTICCODE1_1

Add

653

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

Name of the medication: 1943 Code: 317

Name of Medication	Code	
1975	1976	ANTIINFSTEROIDNAME
		ANTIINFLAMMATORYMEDICATIONN1_1
		ANTIINFLAMMATORYMEDICATIONN2_1
		ANTIINFLAMMATORYMEDICATIONN3_1
		ANTIINFLAMMATORYMEDICATIONN4_1
		ANTIINFLAMMATORYMEDICATIONN5_1

ANTIINFLAMMATORYPILLSCONSUMED

 ANTIINFLAMMATORYMEDICATIONC1_1
 ANTIINFLAMMATORYMEDICATIONC2_1
 ANTIINFLAMMATORYMEDICATIONC3_1
 ANTIINFLAMMATORYMEDICATIONC4_1
 ANTIINFLAMMATORYMEDICATIONC5_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

Name of Medication	Code	
1979	1980	PREGDIABETESMEDICATIONCODE
		DIABETESMEDICATIONNAME1_1
		DIABETESMEDICATIONNAME2_1

 MEDFORDIABETESNAME
 DIABETESMEDICATIONCODE1_1
 DIABETESMEDICATIONCODE2_1

656

e. **Other** OtherMedication

Name of the medication: 1946 Code: 323 OTHERMED1

Name of the medication: 1947 Code: 689

Name of Medication	Code	
1981	1982	OTHERMED2
		OTHERMEDICATIONCODE2

OTHERMEDICATIONCODE1

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"/> <input type="radio"/> See below	See below <input type="text" value="676"/>
674	Second Trimester (months 4-6)	<input checked="" type="radio"/> <input type="radio"/> See below	See below <input type="text" value="677"/>
675	Third Trimester (months 7-9)	<input checked="" type="radio"/> <input type="radio"/> See below	See below <input type="text" value="678"/>

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"/> <input type="radio"/>	<input type="radio"/> WORKTYPE1TRIMESTER
182	Second Trimester (months 4-6)	<input checked="" type="radio"/> <input type="radio"/>	<input type="radio"/> WORKTYPE2TRIMESTER
183	Third Trimester (months 7-9)	<input checked="" type="radio"/> <input type="radio"/>	<input type="radio"/> WORKTYPE3TRIMESTER

9. SMOKEFREQ1TRIMESTER
SMOKENUMCIGS1TRIMESTER
SMOKEFREQ2TRIMESTER
SMOKENUMCIGS2TRIMESTER
SMOKEFREQ3TRIMESTER
SMOKENUMCIGS3TRIMESTER

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"/> See below	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
680	Second Trimester (months 4-6)	<input checked="" type="radio"/> See below	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
681	Third Trimester (months 7-9)	<input checked="" type="radio"/> See below	<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"/> See below	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
683	Second Trimester (months 4-6)	<input checked="" type="radio"/> See below	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
684	Third Trimester (months 7-9)	<input checked="" type="radio"/> See below	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11a. ALCOHOLFREQ1TRIMESTER
ALCOHOLFREQ2TRIMESTER
ALCOHOLFREQ3TRIMESTER

11.b ALCOHOLNUMDRINKS1TRIMESTER
ALCOHOLNUMDRINKS2TRIMESTER
ALCOHOLNUMDRINKS3TRIMESTER

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") SPECIALDIET	<input checked="" type="checkbox"/> No															
	<table border="1"> <thead> <tr> <th>Code</th> <th>Yes</th> <th></th> </tr> </thead> <tbody> <tr> <td>208</td> <td><input checked="" type="checkbox"/></td> <td>209</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/></td> <td></td> </tr> <tr> <td colspan="3">Add</td> </tr> </tbody> </table> SPECIALDIETYES1_1 SPECIALDIETCODE1_1 SPECIALDIETYES2_1 SPECIALDIETCODE2_1	Code	Yes		208	<input checked="" type="checkbox"/>	209		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>		Add			
Code	Yes																
208	<input checked="" type="checkbox"/>	209															
	<input checked="" type="checkbox"/>																
	<input checked="" type="checkbox"/>																
Add																	

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

657

658

City

ZipCode

1921

1922

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

690

691

692

GLASSES PER DAY CITY TOWN TAP WATER
 GLASSES PER DAY WELL TAP WATER
 GLASSES PER DAY STORE BOTTLED WATER
 GLASSES PER DAY DONT KNOW SOURCE

FILTERED CITY TAP WATER YES NO TAP WATER UNKNOWN NUM GLASSES TAKEN
 TAP WATER WELL FILTERED YES NO
 TAP WATER UNKNOWN FILTERED YES NO

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					
1. Bread (white, dark, crisp, whole wheat, mixed grain, french, parisien, toast), flour tortillas, bagels or rolls. <i>See below</i>	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 <i>See below</i>	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 <i>See below</i>	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 <i>See below</i>	2 pieces	<input checked="" type="checkbox"/> 228	<input type="text" value="229"/>	<input type="text" value="230"/>	<input type="text" value="231"/>
5. Pizza <i>See below</i>	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 <i>See below</i>	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 <i>See below</i>	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 <i>See below</i>	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 <i>See below</i>	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) <i>See below</i>	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 <i>See below</i>	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 <i>See below</i>	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 OTHERCEREALPDTCODE Code <input type="text" value="265"/>	<input checked="" type="radio"/> 1 bowl <input type="radio"/> 1 cup 266 <input type="radio"/> 1 tbsp <i>See below</i> <input type="radio"/> 1 piece		<i>See below</i> <input type="text" value="267"/>	<i>See below</i> <input type="text" value="268"/>	<i>See below</i> <input type="text" value="269"/>

Other Codes	Serving size	# of times per month	# of times per week	# of times per Day
<input checked="" type="radio"/> 1 bowl 1949 OTHERCEREALS CODE1_1 <input type="text" value="1948"/>		<input type="text" value="1950"/>	<input type="text" value="1951"/>	<input type="text" value="1952"/>
<input type="radio"/> 1 cup <input type="radio"/> 1 tbsp <input type="radio"/> 1 piece OTHERCEREALSSERVSIZE1_1				
<input type="radio"/> 1 bowl <input type="radio"/> 1 cup <input type="radio"/> 1 tbsp <input type="radio"/> 1 piece		<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>				

14a1. BREADNOTCONSUMEDMARKNEVER BREADCONSUMEDTIMESPERMONTH
BREADCONSUMEDTIMESPERWEEK BREADCONSUMEDTIMESPERDAY

14a2. PASTANOTCONSUMEDMARKNEVER PASTACONSUMEDTIMESPERMONTH
PASTACONSUMEDTIMESPERWEEK PASTACONSUMEDTIMESPERDAY

14a3. PASTRIESNOTCONSUMEDMARKNEVER PASTRIESCONSUMETIMESPERMONTH
PASTRIESCONSUMETIMESPERWEEK PASTRIESCONSUMETIMESPERDAY

14a4. NOCOOKIESCRACKERSMARKNEVER COOKIEBISCUITCRACKERTIMESPERMO
COOKIEBISCUITCRACKERTIMESPERWE COOKIEBISCUITCRACKERTIMESPERDA

14a5. PIZZANOTCONSUMEDMARKNEVER PIZZACONSUMEDTIMESPERMONTH
PIZZACONSUMEDTIMESPERWEEK PIZZACONSUMEDTIMESPERDAY

14a6. NOMEATPASTRIESMARKNEVER MEATPASTRIESCONSUMETIMESPERMON
MEATPASTRIESTAKENTIMESPERWEEK MEATPASTRIESCONSUMETIMESPERDAY

14a7. CEREALSNOTCONSUMEDMARKNEVER CEREALSCONSUMETIMESPERMONTH
CEREALSCONSUMEDTIMESPERWEEK CEREALSCONSUMEDTIMESPERDAY

14a8. NOOATMEALMARKNEVER OATMEALCONSUMEDTIMESPERMONTH
OATMEALCONSUMETIMESPERWEEK OATMEALCONSUMEDTIMESPERDAY

14a9. NORICEPDTSMARKNEVER RICECONSUMETIMESPERMONTH
RICECONSUMETIMESPERWEEK RICECONSUMETIMESPERDAY

14a10. NOCORNPDTSMARKNEVER CORNPDTCONSUMETIMESPERMONTH
CORNPDTCONSUMETIMESPERWEEK CORNPDTCONSUMETIMESPERDAY

14a11. NOWHEATGERMMARKNEVER WHEATGERMCONSUMETIMESPERMONTH
WHEATGERMCONSUMETIMESPERWEEK WHEATGERMCONSUMETIMESPERDAY

14a12. NOBUCKWHEATMILLETMARKNEVER
BUCKWHEATCONSUMETIMESPERMONTH
BUCKWHEATCONSUMEDTIMESPERWEEK
BUCKWHEATCONSUMETIMESPERDAY

14a13. OTHERCEREALPDTSERVINGSIZE
OTHERCEREALPDTTIMESPERMONTH
OTHERCEREALPDTTIMESPERWEEK
OTHERCEREALPDTTIMESPERDAY

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) <i>See below</i>	1 glass	<input checked="" type="checkbox"/> 345	346	347	348
2. Milk / Cream in coffee or tea <i>See below</i>	1 tbsp	<input checked="" type="checkbox"/> 349	350	351	352
3. Sour milk, buttermilk <i>See below</i>	1 glass	<input checked="" type="checkbox"/> 353	354	355	356
4. Yogurt, cultured milk, kefir <i>See below</i>	1 serving	<input checked="" type="checkbox"/> 357	358	359	360
5. Cottage cheese, curd, quark <i>See below</i>	1 serving	<input checked="" type="checkbox"/> 361	362	363	364
6. Milk-based puddings, custards, desserts <i>See below</i>	1 serving	<input checked="" type="checkbox"/> 365	366	367	368
7. Whipped cream (e.g. topping on cakes and other desserts) <i>See below</i>	2 tbsp	<input checked="" type="checkbox"/> 369	370	371	372
8. Ice cream, frozen yogurt <i>See below</i>	1 cone or 1 scoop	<input checked="" type="checkbox"/> 373	374	375	376
9. All types of cheese <i>See below</i>	2 slices or pieces	<input checked="" type="checkbox"/> 377	378	379	380
10. Soups made with milk, cream soups <i>See below</i>	1 bowl	<input checked="" type="checkbox"/> 381	382	383	384
11. Casseroles and dishes containing cheese (e.g. pizza, lasagna, macaroni and cheese, etc.) <i>See below</i>	1 serving	<input checked="" type="checkbox"/> 385	386	387	388
12. Other foods prepared with milk or cheese: Code <input type="text" value="390"/> <i>OtherMilkCheeseFoodCode</i> <i>OtherMilkCheeseFoodServingSize</i>	<input checked="" type="radio"/> 1 glass <input type="radio"/> 1 tbsp ³⁹¹ <input type="radio"/> 1 serving <input type="radio"/> 1 bowl <input type="radio"/> 1 piece		<i>See below</i> <input type="text" value="392"/>	<input type="text" value="393"/>	<input type="text" value="394"/>
Other Codes Serving size # of times per month # of times per week # of times per Day					
<input type="text" value="1953"/>	<input checked="" type="radio"/> 1 glass 1954 <input type="radio"/> 1 tbsp <input type="radio"/> 1 serving <input type="radio"/> 1 bowl <input type="radio"/> 1 piece	<input type="text" value="1955"/>	<input type="text" value="1956"/>	<input type="text" value="1957"/>	
<i>OtherMilkFoodsCode</i> <input type="text"/>	<i>OtherMilkFoodsServSize</i> <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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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

- | | |
|--|---|
| 14b1. MILKNOTCONSUMEDMARKNEVER MILKCONSUMEDTIMESPERMONTH
MILKCONSUMEDTIMESPERWEEK MILKCONSUMEDTIMESPERDAY | 14b11. NOCHEESECASSEROLEDISHMARKNEVER
CHEESECASSEROLEDISHTIMESPERMON
CHEESECASSEROLEDISHTIMESPERWEE
CHEESECASSEROLEDISHTIMESPERDAY |
| 14b2. MILKCREAMNOTCONSUMEMARKNEVER MILKCREAMCONSUMETIMESPERMONTH
MILKCREAMCONSUMETIMESPERWEEK MILKCREAMCONSUMETIMESPERDAY | |
| 14b3. BUTTERMILKNOTCONSUMEMARKNEVER BUTTERMILKCONSUMETIMESPERMONTH
BUTTERMILKCONSUMETIMESPERWEEK BUTTERMILKCONSUMETIMESPERDAY | 12b12. OTHERMILKCHEESEFOODTIMESPERMON
OTHERMILKCHEESEFOODTIMESPERWEE
OTHERMILKCHEESEFOODTIMESPERDAY |
| 14b4. NOYOGURTCULTURED MILK MARKNEVER YOGURTCULTURED MILK TIMESPERWEEK
YOGURTCULTURED MILK TIMESPERWEEK YOGURTCULTURED MILK TIMESPERDAY | |
| 14b5. NOCOTTAGECHEESESECURDMARKNEVER CHEESESECURDCONSUMETIMESPERMONTH
CHEESESECURDCONSUMETIMESPERWEEK CHEESESECURDCONSUMETIMESPERDAY | |
| 14b6. NOPUDDINGCUSTARDMARKNEVER PUDDINGCUSTARDTIMESPERMONTH
PUDDINGCUSTARDTIMESPERWEEK PUDDINGCUSTARDTIMESPERDAY | |
| 14b7. WHIPCREAMNOTCONSUMEMARKNEVER WHIPPEDCREAMTIMESPERMONTH
WHIPCREAMCONSUMETIMESPERWEEK WHIPCREAMCONSUMETIMESPERDAY | |
| 14b8. NOICECREAMFROZENYOGURTMARKNEVE ICECREAMFROZENYOGURTTIMESPERMO
ICECREAMFROZENYOGURTTIMESPERWE ICECREAMFROZENYOGURTTIMESPERDA | |
| 14b9. NOCHEESEMARKNEVER CHEESECONSUMETIMESPERMONTH
CHEESECONSUMETIMESPERWEEK CHEESECONSUMETIMESPERDAY | |
| 14b10. NOMILKCREAMSOUPTIMESPERMONTH
TAKEMILKCREAMSOUPTIMESPERWEEK TAKEMILKCREAMSOUPTIMESPERDAY | |

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		313	314	315																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #0056b3; color: white;"> <th>Other Codes</th> <th>Serving size</th> <th># of times per month</th> <th># of times per week</th> <th># of times per Day</th> </tr> </thead> <tbody> <tr> <td><input type="text" value="1958"/></td> <td><input checked="" type="radio"/> 1 piece 1959</td> <td><input type="text" value="1960"/></td> <td><input type="text" value="1961"/></td> <td><input type="text" value="1962"/></td> </tr> <tr> <td></td> <td><input type="radio"/> 1 serving</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> 1 bowl</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="radio"/> 1 piece</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="text"/></td> <td><input type="radio"/> 1 serving</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td></td> <td><input type="radio"/> 1 bowl</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="text"/></td> <td colspan="4" style="color: red;">OTHERFISHDISHSERVINGSIZE</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="text" value="1960"/>	<input type="text" value="1961"/>	<input type="text" value="1962"/>		<input type="radio"/> 1 serving					<input type="radio"/> 1 bowl					<input checked="" type="radio"/> 1 piece				<input type="text"/>	<input type="radio"/> 1 serving	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="radio"/> 1 bowl				<input type="text"/>	OTHERFISHDISHSERVINGSIZE			
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- 14d1. NOFISHHERRINGMARKNEVER TAKEFISHHERRINGTIMESPERMONTH TAKEFISHHERRINGTIMESPERWEEK FISHHERRINGCONSUMETIMESPERDAY
- 14d2. NOCANTUNAMARKNEVER CANTUNACONSUMETIMESPERMONTH CANTUNACONSUMETIMESPERWEEK CANTUNACONSUMETIMESPERDAY
- 14d3. NOFISHFRIESMARKNEVER FISHFRIESCONSUMEDTIMESPERMONTH FISHFRIESCONSUMEDTIMESPERWEEK FISHFRIESCONSUMEDTIMESPERDAY
- 14d4. NOSALMONDISHMARKNEVER SALMONDISHCONSUMETIMESPERMONTH SALMONDISHCONSUMETIMESPERWEEK SALMONDISHCONSUMETIMESPERDAY
- 14d5. NOOTHERFISHPASTAROLLSMARKNEVER OTHERFISHPASTATAKENTIMESPERMONTH TAKEFISHSOUPPIZZATIMESPERWEEK OTHERFISHPASTATAKENTIMESPERDAY
- 14d6. NOBROILEDSALMONCHARTMARKNEVER BROILEDSALMONCHARTTIMESPERMONTH BROILEDSALMONCHARTTIMESPERWEEK BROILEDSALMONCHARTTIMESPERDAY
- 14d7. NOBAKEDBASSHALIBUTMARKNEVER BASSHALIBUTTUNATIMESPERMONTH BAKEDBASSHALIBUTTIMESPERWEEK BAKEDBASSTUNATIMESPERDAY
- 14d8. NOCODMULLETPERCHMARKNEVER CODMULLETCONSUMETIMESPERMONTH CODMULLETCONSUMETIMESPERWEEK CODMULLETCONSUMETIMESPERDAY
- 14d9. CLAMOYSTERNOTCONSUMEMARKNEVER CLAMOYSTERCONSUMETIMESPERMONTH CLAMOYSTERCONSUMETIMESPERWEEK CLAMOYSTERCONSUMETIMESPERDAY
- 14d10. SHRIMPHELLFISHNOTTAKENMARKNEV SHRIMPHELLFISHTAKENTIMESPERMONTH SHRIMPHELLFISHTAKENTIMESPERWEEK SHRIMPHELLFISHTAKENTIMESPERDAY

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)? PREGMULTIVITAMINSCONSUMEYESNO

No Yes

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"/>

- DIETARYSUPPCODE1_1
- DIETARYSUPPLEMENTTABLETS1_1
- DIETARYSUPPINMILLILITERS1_1
- OTHERDIETARYSUPP21_1
- DIETARYSUPPCODEOTHER1_1
- DIETARYSUPPLEMENTTIMESPERWE1_1
- DIETARYSUPPUNKNOWNFREQUENCY1_1
- DIETARYSUPPSTARTWEEKPREG1_1
- DIETARYSUPPENDWEEKPREG1_1
- DIETARYSUPPENTIREPREG1_1

16 a. What is your height?	HEIGHTINFET	341	feet	342	inches	OR	1528	m	975	cms
b. What was your weight before you became pregnant?	WEIGHTBEFOREPREG	395	pounds	OR	976	kgs	WEIGHTBEFOREPREGINKGS			
c. What was your weight at the end of your pregnancy (before delivery)?	WEIGHTATENDOPREG	396	pounds	OR	977	kgs	WEIGHTENDOPREGINKGS			

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

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

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

Much Lower
 Somewhat lower
 About the same
 Somewhat higher
 Much higher

CHILDSTRISKFORDIABETES

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

BABYSFUTUREDOYOUTHINK

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	BABYSRISKDIABETESFEELCALM
399	<input checked="" type="radio"/> Not at all worried	<input type="radio"/> Somewhat worried	<input type="radio"/> Moderately worried	<input type="radio"/> Very worried	BABYSRISKDIABETESFEELWORRIED
400	<input checked="" type="radio"/> Not at all relaxed	<input type="radio"/> Somewhat relaxed	<input type="radio"/> Moderately relaxed	<input type="radio"/> Very relaxed	BABYSRISKDIABETESFEELRELAXED
401	<input checked="" type="radio"/> Not at all tense	<input type="radio"/> Somewhat tense	<input type="radio"/> Moderately tense	<input type="radio"/> Very tense	BABYSRISKDIABETESFEELTENSE
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	BABYSRISKDIABETESFEELATEASE
403	<input checked="" type="radio"/> Not at all nervous	<input type="radio"/> Somewhat nervous	<input type="radio"/> Moderately nervous	<input type="radio"/> Very nervous	BABYSRISKDIABETESFEELNERVOUS

BABYGENETICTESTDIABETESFEELIN

404	21. Overall, how do you feel about having your baby genetically tested for diabetes risk ?	<input checked="" type="radio"/> Liked it a lot	<input type="radio"/> Liked it a little	<input type="radio"/> It was ok	<input type="radio"/> Disliked it a little	<input type="radio"/> Disliked it a lot
405	22. Do you think having the baby genetically tested was a good decision ?	<input checked="" 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
406	23. If a friend was pregnant, would you recommend she have her baby genetically tested for diabetes risk ?	<input checked="" type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Maybe	RECOMMENDGENETICTESTFRIENDS	

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

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 RELATIONSHIPTOCHILD_MOTHER RELATIONSHIPTOCHILD_FATHER
 Mother Father Other Primary Caretaker Other , specify RELATIONSHIPTOCHILD_OTHERPRIMARY
 Code (office use only) RELATIONTOCHILDCODE RELATIONSHIPTOCHILD_OTHER

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

Mother CHIDLIVWITHWHO_MOTHER
 Step-mother CHIDLIVWITHWHO_STEPMOTHER
 Father CHIDLIVWITHWHO_FATHER
 Step-father CHIDLIVWITHWHO_STEPFATHER
 Brothers or sisters CHIDLIVWITHWHO_BROTHERSORSISTE
 Step-brothers or step-sisters CHIDLIVWITHWHO_STEPBROTHERSORS
 Grandparents CHIDLIVWITHWHO_GRANDPARENTS
 Other, specify
 Code (office use only) CHIDLIVESWITHOTHERCODE1_1
 CHIDLIVESWITHOTHERCODE2_1
 CHIDLIVESWITHOTHERCODE3_1
 CHIDLIVESWITHOTHERCODE4_1
 CHIDLIVESWITHOTHERCODE5_1
 CHIDLIVESWITHOTHERCODE6_1
 CHIDLIVESWITHOTHERCODE7_1
 CHIDLIVESWITHOTHERCODE8_1

Other	Other Code
<input type="text" value="2155"/>	<input type="text" value="2156"/>
<input type="text"/>	<input type="text"/>

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? CHILDPARENTSSTATUS

Married
 Unmarried but living together
 Separated
 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 PARENTSEECHILDTIMESDAYWEEKMONY
 Day Week Month Year 1893 CHILDSPARENTSLIVETOGETHER

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).

CHILDNOTLIVINGWITHMOTHER

- Does not live with mother or female caretaker 1894

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

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

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

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

- 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) 1966 HIGHESTGRADESCHOOLINGHERFINNIS

- 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 HERHIGHESTSCHOOLINGGRADESWED

- 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
MOMWORKOUTSIDEHOME

If yes, How many hours per week do you (she) work?
MOTHERWORKHOWMANYHOURS PERWEEK

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	
<input checked="" type="checkbox"/> Does not live with father or partner 1891	
a. What is his (partners) first language? Code (office use only)	1708 FATHERFIRSTLANGUAGECODE
b. What is his (partners) country of birth? Code (office use only)	1709 FATHERBIRTHCOUNTRYCODE
c. Is this his (partners) first child? 1710 FATHERFIRSTCHILD	<input checked="" type="radio"/> No <input type="radio"/> Yes
d. What is his (partners) highest grade or level of schooling completed? 1711	
<input checked="" type="radio"/> Grades 1-9 FATHERHIGHESTLEVELSCHOOLING <input type="radio"/> Grades 10-12 <input type="radio"/> Graduated High School or awarded a GED <input type="radio"/> Some trade school <input type="radio"/> Graduated from trade school <input type="radio"/> Some college or university <input type="radio"/> Graduated with a bachelor's degree (for example BA, AB or BS degrees) <input type="radio"/> Some graduate or professional school <input type="radio"/> Graduated with a master's degree (for example MA, MS, MBA, MEng, MEd, MSW) <input type="radio"/> Graduated with a doctoral degree (for example MD, DDS, JD, Ph.D., Ed.D degree)	
(For Finland) 1967 HIGHESTLEVELSCHOOLINGHIMFINNIS	
<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 HISHIGHESTSCHOOLINGGRADESWED	
<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	<input checked="" type="radio"/> No <input type="radio"/> Yes
If yes, how many hours per week does he (partner) work? FATHERWORKHOWMANYHOURSPERWEEK	1910
11. What is the biological father's height? 3520 feet 3521 inches OR 3579 m 3580 cms See below	
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 FATHERORPARTNERSMOKE	<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not applicable
If yes,	<input checked="" type="radio"/> No <input type="radio"/> Yes
a. Do you (mother, female primary caretaker living in this household) smoke in the home? 1719 MOMSMOKEINHOME	<input checked="" type="radio"/> No <input type="radio"/> Yes
b. Do you (mother, female primary caretaker living in this household) smoke in the car? 1720	

MOMSMOKEINCAR

11. BIOLOGICALFATHERSHEIGHTINFEET
 BIOLOGICALFATHERSHEIGHTININCHE
 BIOLOGICALFATHERHEIGHTINMETERS
 BIOLOGICALFATHERHEIGHTINCENTIM

13. Does the child's father (or other partner living in this household) currently smoke?* If yes,		FATHERORPARTNERSMOKE	1912	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not applicable																											
a. Does he (child's father or other partner living in this household) smoke in the home?		DOEDHESMOKEINHOME	1722	<input type="radio"/> No <input type="radio"/> Yes																											
b. Does he (child's father or other partner living in this household) smoke in the car?		DOEDHESMOKEINCAR	1723	<input type="radio"/> No <input type="radio"/> Yes																											
14. Does the child regularly spend time with anyone else who smokes?*		CHILDSPENDTIMEWITHSMOKER	1724	<input type="radio"/> No <input type="radio"/> Yes																											
15. Are there any animals or pets in the TEDDY child's house (the household that this form pertains to)? If yes, please tell us what kind of pet and how many:		PETSCHILDHOUSE	1725	<input type="radio"/> No <input type="radio"/> Yes																											
<table border="1"> <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> </table>		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"/>	PETANIMALCAT PETANIMALDOG PETANIMALBIRD PETANIMALGUINEAPIG PETANIMALHAMSTER PETANIMALMOUSE PETANIMALSNAKE PETANIMALRABBIT PETANIMALFISH PETANIMALTURTLE PETANIMALRAT PETANIMALLIZARD PETANIMALOTHER OTHERPETCODE1_1 OTHERPETCODE2_1 OTHERPETCODE3_1	
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"/>																												
<table border="1"> <tr> <td>Other Code</td> <td>PETCODE</td> </tr> <tr> <td><input type="text" value="2140"/></td> <td><input type="text" value="2141"/></td> </tr> <tr> <td><input type="button" value="Add"/></td> <td></td> </tr> </table>		Other Code	PETCODE	<input type="text" value="2140"/>	<input type="text" value="2141"/>	<input type="button" value="Add"/>		HOWMANYOTHERPET1_1 HOWMANYOTHERPET2_1 HOWMANYOTHERPET3_1																							
Other Code	PETCODE																														
<input type="text" value="2140"/>	<input type="text" value="2141"/>																														
<input type="button" value="Add"/>																															
16. Does the TEDDY child live on a farm with animals, or are there animals that live outside the house (the household that this form pertains to)?		TYPEANIMALSATFARM_CAT TYPEANIMALSATFARM_CHICKEN TYPEANIMALSATFARM_COW TYPEANIMALSATFARM_DOG TYPEANIMALSATFARM_DUCK TYPEANIMALSATFARM_GOAT TYPEANIMALSATFARM_GOOSE TYPEANIMALSATFARM_HORSE TYPEANIMALSATFARM_OTHERWHAT TYPEANIMALSATFARM_PIG TYPEANIMALSATFARM_SHEEP	CHILDLIVEONFARMWITHANIMALS 1729	<input type="radio"/> No <input type="radio"/> Yes																											
<table border="1"> <tr> <td><input type="checkbox"/> Cat</td> <td><input type="checkbox"/> Goat</td> </tr> <tr> <td><input type="checkbox"/> Dog</td> <td><input type="checkbox"/> Chicken</td> </tr> <tr> <td><input type="checkbox"/> Cow</td> <td><input type="checkbox"/> Horse</td> </tr> <tr> <td><input type="checkbox"/> Pig</td> <td><input type="checkbox"/> Goose</td> </tr> <tr> <td><input type="checkbox"/> Duck</td> <td><input type="checkbox"/> Other, what?</td> </tr> <tr> <td><input type="checkbox"/> Sheep</td> <td></td> </tr> <tr> <td>Code (office use only)</td> <td><input type="text" value="1730"/></td> </tr> <tr> <td>Other codes</td> <td></td> </tr> <tr> <td><input type="text" value="3714"/></td> <td></td> </tr> <tr> <td><input type="button" value="Add"/></td> <td></td> </tr> </table>		<input type="checkbox"/> Cat	<input type="checkbox"/> Goat	<input type="checkbox"/> Dog	<input type="checkbox"/> Chicken	<input type="checkbox"/> Cow	<input type="checkbox"/> Horse	<input type="checkbox"/> Pig	<input type="checkbox"/> Goose	<input type="checkbox"/> Duck	<input type="checkbox"/> Other, what?	<input type="checkbox"/> Sheep		Code (office use only)	<input type="text" value="1730"/>	Other codes		<input type="text" value="3714"/>		<input type="button" value="Add"/>		TYPEANIMALSATFARMCODE									
<input type="checkbox"/> Cat	<input type="checkbox"/> Goat																														
<input type="checkbox"/> Dog	<input type="checkbox"/> Chicken																														
<input type="checkbox"/> Cow	<input type="checkbox"/> Horse																														
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Other codes																															
<input type="text" value="3714"/>																															
<input type="button" value="Add"/>																															

OTHERANIMALOUTSIDECODE1_1
 OTHERANIMALOUTSIDECODE2_1
 OTHERANIMALOUTSIDECODE3_1
 OTHERANIMALOUTSIDECODE4_1
 OTHERANIMALOUTSIDECODE5_1
 OTHERANIMALOUTSIDECODE6_1
 OTHERANIMALOUTSIDECODE7_1
 OTHERANIMALOUTSIDECODE8_1
 OTHERANIMALOUTSIDECODE9_1
 OTHERANIMALOUTSIDECODE10_1

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"/>	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 StudyContactPersonLastName Last Name

2253 StudyContactPersonFirstName First Name

No change since last submittal of form 3988 NOCHANGEINSTUDYCONTACTPERSONFI

4. Phone number for study contact

2254 PhoneNumberForStudyContact

No change since last submittal of form 3989 NOCHANGEINPHONENUMBERFORSTUDYC

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

2255 2256 2257 DateOfLastStudyVisitDay
DateOfLastStudyVisitMonth
DateOfLastStudyYear

Study participation is ongoing 2258 Study participation has ended 2257 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 NumOfStudyVisitsPerYear

Attends study visits on an as needed basis 3519 AttendsStudyVisitsOnAnAsNeeded

No change since last submittal of form 3991 Nochangeinnumberofstudyvisitsp

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

Yes 2241 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 OtherBiologicalSamplesObtained

Code 2245 BiologicalSamplesCode1

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 2243 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

Local Use Only



60634

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

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:

TITLE1

2. Institution:

No change since last submittal of form

NOCHANGEININSTITUTIONSINCELAST

3. Study Contact Person:

Last Name

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

First Name

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

No change since last submittal of form

NOCHANGEINSTUDYCONTACTPERSONFI

4. Phone Number for Study Contact:

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

No change since last submittal of form

NOCHANGEINPHONENUMBERFORSTUDYC

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

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

STUDYPARTICIPATIONSTATUS

Study participation is ongoing

Study participation has ended

No change since last submittal of form

NOCHANGEINDATEOFLASTSTUDYVISIT

Local Use Only

60634

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?

- Yes No **HASCHILDPROVIDEDBLOODSAMPLES**
- 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)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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BIOLOGICALSAMPLESCODE2

Code (office
use only)

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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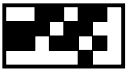
MEDICATIONNAME2**MEDICATIONCODE2**

Code (office
use only)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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- No change since last submittal of form **NOCHANGEINMEDICATIONSRECEIVEDA**

Local Use Only



60634

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

Yes No

CHILDRECEIVEDANYVACCINE

No change since last submittal of form

NOCHANGEINTHEVACCINATIONSRECEI

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

VACCINE1INFO

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?

Yes No

HASTHECHILDRECEIVEDANYDIETARYS

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

DIETARYSUPPLEMENTINFO

DIETARYSUPPLEMENTCODE1

Code (office
use only)DIETARYSUPPLEMENT2INFO
DIETARYSUPPLEMENT2NAME

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			
115584	A0132827A	FIN - University of Turku		<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_GLUCOSE

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	<input type="text"/> TIME_PROCESSED
-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) <input type="text"/> BLOOD_GLUCOSE_MGDL <input type="text"/> mmol/L <input type="text"/> 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) <input type="text"/>	<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"/>

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 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.

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		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 >A@96;EF3@57BDFAFA5A>			

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: *

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

Mother Father Other Primary Caretaker
 Code Other Mother + Father completed form together

RELATIONSHIPTOTEDDYC_FATHER
 RELATIONSHIPTOTEDDYC_MOTHER
 RELATIONSHIPTOTEDDYC_MOTHERFATHER
 RELATIONSHIPTOTEDDYC_OTHER
 RELATIONSHIPTOTEDDYC_OTHERPRIMAR

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	<input checked="" type="radio"/> Very Important	<input type="radio"/> Important	<input type="radio"/> Not So Important
3534	Helping science discover the causes of t1d HELPSCIENCEDISCOVERTYPE1D	<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 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	
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) (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
3542 Toy Chest for 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
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

3540. GIFTSFORCHILDREN

3541. GIFTSFORPARENTS

3542. TOYCHESTFORCHILDREN

3543. PAYMENTREIMBURSEMENTFORVISITS

3544. PAYMENTSFORSTOOLSAMPLES

3545. GIFTCARDS

3581. VALETANDORFREEPARKINGGEO

3582. MILEAGECOMPENSATIONGEO

3583. BONUSECONSITSTOOLSAMPLEGEO

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

3553

b. Would you be interested in attending a TEDDY party in the future?

Yes No

3554

c. How would you like to receive the TEDDY newsletter?

Mail Email

3555

d. Do you think it is a good idea to give some of the clinic visit payment/ reimbursement to your TEDDY child?

(For Colorado and Washington)

Yes No

(For Georgia/Florida)

Yes No Already doing this

3584

(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?

Age of the TEDDY child

3552. INTERESTPARTIPARENTFOCUSGROUP

3553. INTERESTTEDDYPARTYINFUTURE

3554. RECEIVENEWSLETTERONS_BYEMAIL

3554. RECEIVENEWSLETTERONS_BYMAIL

3555. GIVECLINICVISITPAYMENTTOCHILD

3584. CLINICVISITPAYMENTTOCHILDGEFL

3556. AGETOgiveCHILDCASHFORVISIT

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	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	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	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	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	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	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	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	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	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	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

3557. REMINDERSFORTHETEDDYVISITS

3558. WORKINGWITHTHETEDDYSTAFF

3559. GETTINGMYQUESTIONSANSWERED

3560. DAYTIMEVISITSCHEDULED

3561. WAITBEFORETHETEDDYVISITSTARTS

3562. CLINICSETTINGORENVIRONMENT

3563. TIMETOCOMPLETEVISIT

3564. TRANSPORTTOTEDDYVISIT

3565. PARKINGFORATEDDYVISIT

3566. MAILINGPOOPSAMPLECENTER

3680. MAILINGBLOODSAMPLECENTERGER

7. What else can we do to make TEDDY a better experience for you and your family?TEDDYBETTEREXPERIENCECODE1
TEDDYBETTEREXPERIENCECODE2
TEDDYBETTEREXPERIENCECODE3

Codes

3522

3523

3524

8. Have you ever thought about leaving TEDDY? 3525 Yes No THOUGHTABOUTLEAVINGTEDDYLEAVINGTEDDYCODE1
LEAVINGTEDDYCODE2
LEAVINGTEDDYCODE3

Codes

3569

3570

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	<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	<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	<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)	<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	<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	<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	<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	<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	<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

3716. SEEDOCTORDURINGOFFICEHOURFIN

3717. CALDOCTORWHENNECESSARYFIN

3718. CALLSTUDYNURSENECESSARYFIN

3719. SMALLGIFTSRECEIVEDVISITFIN

3720. TEDDYNEWSLETTERSFIN

3721. CHRISTMASCARDFIN

3722. CHRISTMASCALENDARFIN

3723. TEDDYHOMEPAGESFIN

3724. INTERTEDDYHOMEPAGESFIN

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?

- 3725
- I would always have used BUSINESSHOURSUSEDVISITFIN
 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
 Code 1 Code 2 WAITINGAREATOYS_CODE1FIN
 WAITINGAREATOYS_CODE2FIN
- I wish the waiting area had
 Code 1 Code 2 WAITINGAREAHAD_CODE1FIN
 WAITINGAREAHAD_CODE2FIN

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

- 3729
- We don't usually have to wait WAITBEFOREADMITINLABFIN
 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 EVENINGEVENTATTENDFI_IWOULDVERYL
 I might possibly attend EVENINGEVENTATTENDFI_IMIGHTPOSSI
 I would not attend EVENINGEVENTATTENDFI_IWOULDNOTAT
 I'd like to attend, but for practical reasons I don't believe I could attend an evening event EVENINGEVENTATTENDFI_IDLIKETOATT
 I support a smaller event to which only about 50 families at a time would be invited EVENINGEVENTATTENDFI_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_IWOULDLIKE2
 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 IWOULDLIKE_CODE1FIN
 Code 2 IWOULDLIKE_CODE2FIN

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	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	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	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	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	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	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	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	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	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

3688. MOREEXPENSIVEGIFTSFORTHECHILDR

3689. SMALLGIFTSFORTHECHILDRENSWE

3690. CHRISTMASCARDSWE

3691. INFOLETTERABOUTHAPPENINGINTEDD

3692. PARENTMEETINGTEDDYSWE

3693. TEDDYLOCALHOMEPAGESWE

3694. TEDDYINTERNATIONALHOMEPAGE

3695. REIMBURSEMENTFORTRAVELSWE

3696. TEDDYPARKINGSWE

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?

Yes No REMINDERTOCOMETEDDYCLINICSWE

3698

How would you like to be reminded?

email
 mail
 telephone
 sms
LIKETOBEREMINDEDSWE

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)	
Gifts (HIPP-package, towel...)Which gift did you like the most? <input type="text" value="3681"/> Code <input type="text" value="3668"/> Do you have any ideas for new presents? <input type="text" value="3682"/> Code <input type="text" value="3669"/> Code <input type="text" value="3670"/>	<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 GIFTSHIPPACKAGETOWELGER <small>3667</small> GIFTYOULIKETHEMOSTGER CODEFORTHEGIFTYOULIKETHEMOSTGE HAVEANYIDEASNEWPRESENTSGER CODE1FORANYIDEASFORNEWPRESENTS CODE2FORANYIDEASFORNEWPRESENTS
Payments PAYMENTSFORVISITSGER for visits <small>3683</small> LIKETOBEREMINDEDSWE for digital scale <small>3671</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 <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
Communication	
Telephone calls with the TEDDY staff <small>3672</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
Personal meeting with the TEDDY staff <small>3673</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
Meeting with TEDDY doctors <small>3684</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
Newsletter <small>3685</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
Christmas and birthday cards <small>3674</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
Painting contest <small>3675</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
International TEDDY website <small>3686</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
Planned activities	
Local TEDDY website <small>3687</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
TEDDY summer party in Munich <small>3676</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

3672. TELECALLSWITHTEDDYSTAFFGER

3673. PERSMEETWITHTEDDYSTAFFGER

3684. MEETINGWITHTEDDYDOCTORSGER

3685. NEWSLETTERGER

3674. CHRISTMASBIRTHCARDSGER

3675. PAINTINGCONTESTGER

3686. INTERNATIONALTEDDYWEBSITEGER

3687. LOCALTEDDYWEBSITEGER

3676. TEDDYSUMMERPARTYMUNICHGER

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? REMINDEDNEXTSTOOLSAMPLEVISITGE	<input checked="" type="radio"/> Per mailing <input type="radio"/> Per Email	<input type="radio"/> Per telephone <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"/> Thursday	<input type="radio"/> Tuesday <input type="radio"/> Friday <input type="radio"/> Wednesday <input type="radio"/> Anytime
3679	Which time of the day is best for you to be reached via telephone? TIMEOFDAYTOREACHVIATELEGER	<input checked="" type="radio"/> 8:00-10:00 <input type="radio"/> 14:00-16.00	<input type="radio"/> 10:00-12:00 <input type="radio"/> 16:00-18:00 <input type="radio"/> 12:00-14:00 <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.

Local Use Only

SubjectID

Date you completed this questionnaire:

 / /

DATECOMPLETEDQUESTIONNAIREAGE

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

What is your relationship to the child? RELATIONSHIPTOCHILD_

- Mother Father Other Primary Caretaker Other, specify
MOTHER FATHER OTHERPRIMARY 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 FEELINGHUNGRY
2. Feeling thirsty	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 FEELINGTHIRSTY
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 HAVINGTOGOBATHROOMTOOOFTEN
4. Having tummy aches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HAVINGTUMMYACHES
5. Having headaches	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HAVINGHEADACHES
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 FEELINGHUNGRY
7. Going "low"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 GOINGLOW
8. Going "high"	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 GOINGHIGH
9. Feeling tired	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 FEELINGTIRED
10. Getting shaky	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 GETTINGSHAKY
11. Getting sweaty	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 GETTINGSWEATY
12. Feeling dizzy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 FEELINGDIZZY
13. Feeling weak	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 FEELINGWEAK
14. Having trouble sleeping	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 HAVINGTROUBLESLEEPING
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 GETTINGCRANKYORGRUMPY

SubjectID

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

SubjectID

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 WORRYINGABOUTGOINGLOW
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 WORRYINGABOUTGOINGHIGH

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 TELLINGDOCTORSHOWFEELS
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 ASKINGDOCTORSQUESTIONS
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 EXPLAININGILLNESSTOPEOPLE
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 EMBARRASSEDABOUTHAVINGDIABETES

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

SubjectID

EVENT

HOW OFTEN?

1=Never,
2=Rarely,
3=Sometimes,
4=Often,
5=Very Often

HOW DIFFICULT?

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):	662	DrawSite
<input checked="" type="radio"/> Venous	<input type="radio"/> Capillary	

<input type="radio"/> Left antecubital	<input checked="" type="radio"/> Left Heel	
<input type="radio"/> Right antecubital	<input type="radio"/> Right Heel	
<input checked="" type="radio"/> Left Hand	<input type="radio"/> Finger	
<input type="radio"/> Right Hand	<input type="radio"/> Other	
<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
<input type="radio"/> Yes	<input checked="" type="radio"/> 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
<p>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"?</p> <p style="text-align: center;">SubjParticipationNewStudy</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No 2235</p> <p>If yes, please complete a new "Participant in Non-TEDDY Research Form".</p>		
Comments	<input type="text" value="2240"/>	
<input type="button" value="Save"/> <input type="button" value="Print"/> <input type="button" value="Close"/>		

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: 102 103 104 *

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

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

 Not at all calm Somewhat calm Moderately calm Very calm **BabysRiskDiabetesFeelCalm**
 Not at all worried Somewhat worried Moderately worried Very worried **BabysRiskDiabetesFeelWorried**
 Not at all relaxed Somewhat relaxed Moderately relaxed Very relaxed **BabysRiskDiabetesFeelRelaxed**
 Not at all tense Somewhat tense Moderately tense Very tense **BabysRiskDiabetesFeelTense**
 Not at all at-ease Somewhat at-ease Moderately at-ease Very at-ease **BabysRiskDiabetesFeelEase**
 Not at all nervous Somewhat nervous Moderately nervous Very nervous **BabysRiskDiabetesFeelNervous**

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

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

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:**TannerVisit** 8 year 12 year 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



16732

SubjectID

TEDDY Tanner Stage -- Female (≥ 8 years)

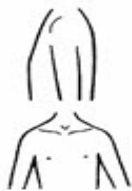
1. Date you completed this questionnaire:

 / /

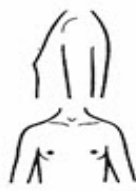
(DD/MMM/YYYY - Example 01/JAN/2004)

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

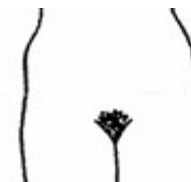
1. There is no pubic hair

 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.

Haveyoustartedyourperiod4. Have you started your period? Yes No

If Yes, Date of First Period:

 / /

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



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:

TannerVisit

Visit:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="radio"/> 8 year | <input type="radio"/> 12 year |
| <input type="radio"/> 8 year 6 month | <input type="radio"/> 12 year 6 month |
| <input type="radio"/> 9 year | <input type="radio"/> 13 year |
| <input type="radio"/> 9 year 6 month | <input type="radio"/> 13 year 6 month |
| <input type="radio"/> 10 year | <input type="radio"/> 14 year |
| <input type="radio"/> 10 year 6 month | <input type="radio"/> 14 year 6 month |
| <input type="radio"/> 11 year | <input type="radio"/> 15 year |
| <input type="radio"/> 11 year 6 month | <input type="radio"/> 15 year 6 month |



22714

Local Use Only

SubjectID

TEDDY Tanner Stage -- Boys(≥ 8 years)

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

Ethnicity

Mom DOB Year: _____ Father DOB Year: _____

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)

MomSchoolingCompleted

(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

MomSchoolingCompletedFin

(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

MomSchoolingCompletedSwe

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

(check all that apply)

WHICHFAMILYMEMT1D_Mother
WHICHFAMILYMEMT1D_Father
WHICHFAMILYMEMT1D_SIBLING

Study History

Does this family have other children already enrolled in this study? **OtherChildEnrolled**

No Yes

If "Yes", please provide other children's Local Code(s):

OTHERCHILDMASKID#_1

Add

Was the Mother involved in the pregnancy study? * **MomEnrolledPregStudy**

No Yes

If "Yes", please provide Mother's Local Code: _____ **Mom_MaskID**

HLA Sample Information*

Sample draw date: _____ 2009 HLA Screening Sample Number: _____

HLADrawAge **HLASampleNumber**

Save Print Clear Close

Event_age

Race_White

Race_BlackorAfricanAmerica

Race_Asian

Race_NativeHawaianorotherPac

Race_NativeAmericanAlaskanNat

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:

DateReviewedDay DateReviewedMonth DateReviewedYear

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	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

<p>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.*</p>	
<p>a. You have been able to laugh and see the funny side of things *</p> <p><input type="radio"/> As much as I always could</p> <p><input type="radio"/> Not quite so much now</p> <p><input type="radio"/> Definetely not so much now</p> <p><input type="radio"/> Not at all</p>	<p>1158</p> <p>WhenDoSeeFunnySideOfThings</p>
<p>b. You have looked forward with enjoyment to things*</p> <p><input type="radio"/> As much as I always did</p> <p><input type="radio"/> Rather less than I used to</p> <p><input type="radio"/> Definetely less than I used to</p> <p><input type="radio"/> Hardly at all</p>	<p>1159</p> <p>YouLookForwardToEnjoyThings</p>
<p>c. You have blamed yourself unnecessarily when things went wrong*</p> <p><input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> Not very often <input type="radio"/> Never</p>	<p>1160</p> <p>BlameYourselfThingsWentWrong</p>
<p>d. You have been anxious and worried for no good reason*</p> <p><input type="radio"/> Not at all <input type="radio"/> Hardly ever <input type="radio"/> Sometimes <input type="radio"/> Very often</p>	<p>1161</p> <p>AnxiousWorryForNoReason</p>
<p>e. You have felt scared or panicky for no very good reason*</p> <p><input type="radio"/> Quite a lot <input type="radio"/> Sometimes <input type="radio"/> Not much <input type="radio"/> Not at all</p>	<p>1162</p> <p>ScaredPanickyForNoReason</p>
<p>f. Things have been getting on top of you*</p> <p><input type="radio"/> Most of the time you haven't been able to cope at all</p> <p><input type="radio"/> Sometimes you haven't been coping as well as usual</p> <p><input type="radio"/> Most of the time you have coped quite well</p> <p><input type="radio"/> You have been coping as well as ever</p>	<p>1163</p> <p>WhenThingsGetOnTopOfYou</p>
<p>g. You have been so unhappy that you have had difficulty sleeping*</p> <p><input type="radio"/> Most of the time <input type="radio"/> Sometimes <input type="radio"/> Not very often <input type="radio"/> Never</p>	<p>1164</p> <p>BeenUnhappyDifficultSleeping</p>
<p>h. You have felt sad and miserable*</p> <p><input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> Not very often <input type="radio"/> Never</p>	<p>1165</p> <p>FeltSadandMiserable</p>
<p>i. You have been so unhappy that you have been crying*</p> <p><input type="radio"/> Most of the time <input type="radio"/> Quite often <input type="radio"/> Only occasionally <input type="radio"/> Never</p>	<p>1166</p> <p>BeenUnhappyCrying</p>
<p>j. The thought of harming yourself has occurred to you*</p> <p><input type="radio"/> Quite often <input type="radio"/> Sometimes <input type="radio"/> Hardly ever <input type="radio"/> Never</p>	<p>1167</p> <p>ThoughtOfHarmingYourself</p>
<p>8. Please read each statement below and mark whether you agree or disagree with the statement.</p>	
<p>a. I can do something to reduce my child's risk of developing diabetes</p> <p><input type="radio"/> Strongly agree <input type="radio"/> Agree <input type="radio"/> Neutral <input type="radio"/> Disagree <input type="radio"/> Strongly disagree</p>	<p>1168</p> <p>ICanReduceChildriskDiabetes</p>
<p>b. Medical professionals can do something to reduce my child's risk of developing diabetes</p> <p><input type="radio"/> Strongly agree <input type="radio"/> Agree <input type="radio"/> Neutral <input type="radio"/> Disagree <input type="radio"/> Strongly disagree</p>	<p>1169</p> <p>MedProfReduceChildRiskDiabetes</p>
<p>c. It is up to chance or fate whether my child develops diabetes</p> <p><input type="radio"/> Strongly agree <input type="radio"/> Agree <input type="radio"/> Neutral <input type="radio"/> Disagree <input type="radio"/> Strongly disagree</p>	<p>1170</p> <p>ChildDiabetesChanceOrFate</p>

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:

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

(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"/> at-ease	STAICHILDRENATEASEVery
f.	<input type="radio"/> Not at all nervous	<input type="radio"/> Somewhat nervous	<input type="radio"/> Moderately nervous	<input type="radio"/> Very nervous	STAICHILDRENNERVOUS

Local Use Only



4273

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:

Local Use Only

57771

SubjectID

STAI and Well-Being Question (for parents)

Date you completed this questionnaire:

 / /

(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_MOTHER

RELATIONSHIPTOCHILD_FATHER

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

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:**

- 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"/> 4212 months OR <input type="text"/> 4213 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) Dentalenameldefects	<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	<input type="radio"/> Mail <input type="radio"/> Email <input type="radio"/> Phone <input type="radio"/> In Person
---	--

Date of Interview/Date Form was Reviewed:	<input type="text" value="4142"/> <input type="text" value="4143"/> <input type="text" value="4144"/> InterviewReviewFormDateDay InterviewReviewFormDateMonth InterviewReviewFormDateYear
---	--

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

INCOMPLETE CONTACT:

Date of Contact Attempt	<input type="text" value="4138"/> <input type="text" value="4139"/> <input type="text" value="4140"/> DataContactAttemptDay DataContactAttemptMonth DataContactAttemptYear
-------------------------	---

Status of contact attempt:	<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
----------------------------	---

PERMISSION TO CONTACT:

<input type="checkbox"/> Participant requested NO FUTURE CONTACT (check this only if the family requests that we not contact them again)	ParticipantrequestedNOFUTURECO
---	---

1. Date you completed this questionnaire:	<input type="text" value="4114"/> <input type="text" value="4115"/> <input type="text" value="4116"/>
---	---

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

We last had contact with you on:	<input type="text" value="4119"/> <input type="text" value="4120"/> <input type="text" value="4121"/>
----------------------------------	---

Keep this date in mind for the following questions.

3. Since our last contact with you, has your child been diagnosed with type 1 diabetes?	<input type="radio"/> Yes <input type="radio"/> No ChildDiagnosedT1DM
---	--

IF YES:

a. What was the date of diagnosis of diabetes?	<input type="text" value="4123"/> <input type="text" value="4124"/> <input type="text" value="4125"/> 1DMDxDateDay 1DMDxDateMonth 1DMDxDateYear
--	--

b. If your child has been diagnosed with diabetes, has insulin been started?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown HasInsulinBeenStarted
--	---

4. Since our last contact with you, has you child been diagnosed with celiac disease?	<input type="radio"/> Yes <input type="radio"/> No HasBeenDiagnosedCeliacDisease
---	---

IF YES:

a. What was the date of diagnosis of celiac disease?	<input type="text" value="4128"/> <input type="text" value="4129"/> <input type="text" value="4130"/> DateDxCeliacDiseaseDay DateDxCeliacDiseaseMonth DateDxCeliacDiseaseYear
--	--

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.

5. Would you like to have TEDDY contact you about re-activating or re-joining?	<input type="radio"/> Yes <input type="radio"/> 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	<input type="text"/>	Visit Location Code	<input type="text"/>
----------------	----------------------	---------------------	----------------------

TEDDY Staff Code	<input type="text"/>
------------------	----------------------

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)
 Yes (Fill in the table)
 The baby was never breast fed
- ChildGetsBreastFeedOrNot

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 type="text" value="774"/>	<input type="text" value="775"/>	<input type="text" value="776"/>	BreastFeedStopDate	OR	at the age of: <input type="text" value="777"/>	BreastFeedStopAge
					<input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months	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 type="text" value="815"/>	<input type="text" value="816"/>	<input type="text" value="817"/>	<input type="text" value="1963"/> <input type="text" value="1974"/>
<input type="radio"/> Liquid concentrate	LiquidPowderCode		InfantFormulaStopAge	ChangdFormulaBrandTypeCode2
<input type="radio"/> Ready to feed				
<input type="radio"/> Powder	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Liquid concentrate				
<input type="radio"/> Ready to feed				
<input type="radio"/> Powder	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input 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?*			
<input type="radio"/> No <input type="radio"/> 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	819	820	<input type="radio"/> No <input type="radio"/> Yes
b. Cereal or wheat avoidance due to allergy in the child	822	823	<input type="radio"/> No <input type="radio"/> Yes
c. Gluten-free diet due to celiac disease in the child	825	826	<input type="radio"/> No <input type="radio"/> Yes
d. Vegetarian Diet What types of food does your child eat on this vegetarian diet?	828	829	<input type="radio"/> No <input type="radio"/> Yes
<input type="checkbox"/> Plant products <input type="checkbox"/> Milk and milk products <input type="checkbox"/> Eggs <input type="checkbox"/> Fish			
e. Kosher Diet	832	833	<input type="radio"/> No <input type="radio"/> Yes
f. Other Diet Code	837	835	<input type="radio"/> No <input type="radio"/> Yes
1935	1936	1937	<input type="radio"/> No <input type="radio"/> Yes
			<input type="radio"/> No <input type="radio"/> Yes
<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

AllegoryCode1_1 AllergyStartedMonths1_1 AllergySymptomsCode11_1 AllergySymptomsCode21_1 AllergySymptomsCode31_1

Add

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

WeightPoundsDynamic WeightOuncesDynamic WeightKgsDynamic HeightInchesDynamic HeightCmsDynamic

Add

2128, 2129, 2130

6. Vaccinations - Has the child been given any vaccinations since the last TEDDY visit?*			
<input type="radio"/> No <input type="radio"/> Yes 888		ChildGivenVaccineOrNot	
Was the child's vaccination card checked by the TEDDY staff member?		<input type="radio"/> No <input type="radio"/> 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	955 956 957	958 959 960	961 962 963
Code 973			
Other	964 965 966	967 968 969	970 971 972
Code 974			
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 influenza 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

7. 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 1010

Type of preparation and Brand Name:Code	drop(s)	dropper(s)	milliliter(s)	tablet(s)	Other	Other Code	How many times a week?	Started (Age in months)	Stopped (Age in months)
1011	1012	1534	1535	1536	1537	1538	1013	1014	1016
<input type="button" value="Add"/>									

dietarysupp

DietarySuppMilliliters

DietarySuppAgeStopped

DietarySuppDrops

DietraySuppTablets

DietarySuppAgeStarted

DietraySuppDroppers

DietraySuppOther

DietarySuppNumPerWeek

DietarySuppCode

OtherDietarySuppCode

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

DATEILLNESSAPPEAREDAGE10_1

2726

No

IllnessDiagnosisCode

Yes, Measured

Diagnosed by parent

Yes, Not Measured

Diagnosed by health care provider 2727

No Symptoms

Illness symptom code1 Illness symptom code2
Illness symptom code3

IllnessFever

IllnessDiagnosis

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

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)
--	--	--

3750	3739 3740	3741 3742
ChronicIllnessICD10Code1_1		

Add

AGEDIAGNOSISCHRONICILLNESS1_1

AGECHRONICILLNESSREMISSION1_I

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
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	ReasonForHospitalizationCod10_1 <input type="text" value="2162"/>	2163 <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	<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, gymboree, 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"/>	* <input type="text"/>
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TEDDY Staff Code	<input type="text"/>	*
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Visit	2264	VisitNum				
<input type="radio"/>	27 months	<input type="radio"/>	30 months	<input type="radio"/>	33 months	<input type="radio"/>
<input type="radio"/>	36 months	<input type="radio"/>	39 months	<input type="radio"/>	42 months	<input type="radio"/>
<input type="radio"/>	45 months	<input type="radio"/>	48 months	<input type="radio"/>	51 months	<input type="radio"/>
<input type="radio"/>	54 months	<input type="radio"/>	57 months	<input type="radio"/>	60 months	<input type="radio"/>
<input type="radio"/>	63 months	<input type="radio"/>	66 months	<input type="radio"/>	69 months	<input type="radio"/>
<input type="radio"/>	72 months					

Persons(s) Interviewed	2272	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Other Primary Caretaker	<input type="checkbox"/>	Other
Persons(s) Interviewed Other Code	<input type="text"/>	2273	OtherPersonInterviewedCode						

1. Child's Early Diet * 2265

Does the child now get any breast milk?

ChildGetsBreastFeedOrNot

- 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: years months

BREASTFEEDSTOPDATEAGE

BREASTFEEDSTOPDATE1

2. Allergies : * Does the child have any new allergies? 2274

- No
 - Yes
- 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

years years

months months

AllergyCode1_1

DATE ALLERGY STOPPED

AllergyCode1_1

- No
- Yes

- Skin test DiagnosisType1_1
- Blood test 2287
- Challenge test
- Other clinical test
- No clinical test was done
- Do not know whether test was done

HEALTHCAREPROV1RECOMMENDORNOT

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

Add

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>			

Other Diet (Specify and Code)	Started (years and months)	Stopped (years and months)	Recommended by a health care provider?
2748 2750 <small>Add OtherDietSpecify1_1 OtherDietCode1_1</small>	2744 years 2745 months <small>Age Other Diet Started</small>	2746 years 2747 months <small>Age Other Diet Stopped</small>	<input type="radio"/> No <input type="radio"/> Yes 2749 <small>OtherDietRecommendedbyprovi1_1</small>

OTHERDIETSTARTEDMON1_1
OTHERDIETSTARTEDYRS1_1

OTHERDIETSTOPPEDMON1_1
OTHERDIETSTOPPEDYRS1_1

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
- MEASLES1STVACCDATEAGE
- VARICELLA3RDVACCDATEYEAR
- DTP2NDVACCDATEAGE
- MEASLES2NDVACCDATEAGE
- VARICELLADATEOF2NDVACCINEDAY
- DTP3RDVACCDATEAGE
- MEASLESDATEOFTHIRDVACCINEAGE
- FO INFLUENZA1VACCAGE
- DTP4THVACCDATEAGE
- HEPATITISA1STVACCAGE
- INFLUENZA2VACCAGE
- DTP5THVACCDATEAGE
- HEPATITISA2VACCAGE
- INFLUENZA3VACCAGE
- TD1STVACCDATEAGE
- HEPATITISA3VACCAGE
- INFLUENZA4VACCAGE
- TD2NDVACCDATEAGE
- HEPATITISA4VACCAGE
- INFLUENZA5VACCAGE
- TD3RDVACCDATEAGE
- HEPATITISA5VACCAGE
- TD4THVACCDATEAGE
- HEPATITISB1STVACCDATEAGE
- ROTAVIRUS1VACCAGE
- TD5THVACCDATEAGE
- HEPATITISB2NDVACCDATEAGE
- ROTAVIRUS2VACCAGE
- POLIO1STVACCDATEAGE
- HEPATITISB3RDVACCDATEAGE
- ROTAVIRUS3VACCAGE
- POLIO2NDVACCDATEAGE
- HEPB5THVACCINATEDATEAGEFORGERMA
- ROTAVIRUS4VACCAGE
- POLIO3RDVACCDATEAGE
- HEPATITISAANDB1VACCAGE
- ROTAVIRUS5VACCAGE
- POLIO4THVACCDATEAGE
- HEPATITISAANDB2VACCAGE
- OTHERDYNVACCINATIONCODE11_1
- POLIO5THVACCINATIONDATEAGEF
- HEPATITISAANDB3VACCAGE
- OTHERDYNVACCINATIONCODE12_1
- OR HIB1STVACCDATEAGE
- HEPATITISAANDB4VACCAGE
- OTHERDYNVACCINATIONCODE13_1
- HIB2NDVACCDATEAGE
- HEPATITISAANDB5VACCAGE
- OTHERDYNVACCINATIONCODE41_1
- HIB3RDVACCDATEAGE
- VARICELLA1STVACCDATEAGE
- OTHERDYNVACCINATIONCODE42_1
- HIB4THVACCDATEAGE
- VARICELLA2NDVACCINATIONDATEAGE
- HIB5THVACCINATIONDATEAGEFORGE
- VARICELLA3RDVACCDATEDAY

Vaccinations continued									
Vaccination	Date of fourth vaccine (DD / MMM/ YYYY)			Date of fifth vaccine (DD / MMM/ YYYY)					
Diphtheria, Tetanus, Pertussis (DTP or DtaP)	2494	2495	2496	2497	2498	2499			
OR Diphtheria Tetanus (Td/DT)	2500	2501	2502	2503	2493	2492			
Polio (OPV or IPV)	2507	2508	2509	3263	3264	3265	(For Germany)		
Haemophilus influenzae B (HiB)	2510	2511	2512	3266	3267	3268	(For Germany)		
Measles, Mumps, Rubella (MMR)									
Hepatitis A	2527	2528	2529	2530	2531	2532			
Hepatitis B (HB)	3269	3270	3271	3272	3273	3274	(For Germany)		
Hepatitis A & B (combination)	2533	2534	2535	2536	2537	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)	2539	2540	2541	2542	2543	2544			
Rotavirus	2545	2546	2547	2548	2549	2550			
Other									
Code	2525			2516	2517	2518	2519	2520	2521
Other									
Code	2526			2522	2523	2524	2504	2505	2506
Other									
Code	2557			2551	2552	2553	2554	2555	2556
Other									
Code	2564			2558	2559	2560	2561	2562	2563
Other Code	Date of fourth vaccine			Date of fifth vaccine					
3512	3513	3506	3507	3508	3509	3510			
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	DTAPIVHIBFINDATEAGE1
DTaP-IPV-Hib	2781	2782	2783	2784	2785	2786	2787	2788	2789	DTAPIVHIBFINDATEAGE2
MPR	2796	2797	2798	2799	2800	2801	2802	2803	2804	DTAPIVHIBFINDATEAGE3
DTaP-IPV	2873	2874	2875	2876	2877	2878	2879	2880	2881	DTAPIVHIBFINDATEAGE4
Rotavirus	2888	2889	2890	2891	2892	2893	2894	2895	2896	DTAPIVHIBFINDATEAGE5
Hepatiitti A (HAV)	2903	2904	2905	2906	2907	0908	2909	2910	2911	MPRFINLANDDATE1AGE
Hepatiitti B (HBV)	2751	2752	2753	2754	2755	2756	2757	2758	2759	MPRFINLANDDATE2AGE
Hepatiitti A ja hepatiitti B	2918	2919	2920	2921	2922	2923	2924	2925	2926	MPRFINLANDDATE3AGE
(TBE)	2933	2934	2935	2936	2937	2938	2939	2040	2941	MPRFINLANDDATE4AGE
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	MPRFINLANDDATE5AGE
Vesirokko	2826	2827	2828	2829	2830	2831	2832	2833	2834	ROTAVIRUSFINLANDDATE1AGE
Muu 2871	2841	2842	2843	2844	2845	2846	2847	2848	2849	ROTAVIRUSFINLANDDATE2AGE
Muu 2872	2856	2857	2858	2859	2860	2861	2862	2863	2864	ROTAVIRUSFINLANDDATE3AGE
Muu 2978	2963	2964	2965	2966	2967	2968	2969	2970	2971	ROTAVIRUSFINLANDDATE4AGE
										ROTAVIRUSFINLANDDATE5AGE
										HEPATIITIAFINLANDDATE1AGE
										HEPATIITIAFINLANDDATE2AGE
										HEPATIITIAFINLANDDATE3AGE
										HEPATIITIAFINLANDDATE4AGE
										HEPATIITIAFINLANDDATE5AGE
										HEPATIITIBFINDATE1AGE
										HEPATIITIBFINDATE2AGE

ROKOTUS (For Finland)	4. rokotuksen päivämäärä (DD / MMM / YYYY)			5. rokotuksen päivämäärän (DD / MMM / YYYY)			
Tuberkuloosi	2775	2776	2777	2778	2779	2780	VARICELLAFINDATE1AGE
DTaP-IPV-Hib	2790	2791	2792	2793	2794	2795	VARICELLAFINDATE2AGE
MPR	2805	2806	2807	2808	2809	2810	VARICELLAFINDATE3AGE
DTaP-IPV	2882	2883	2884	2885	2886	2887	VARICELLAFINDATE4AGE
Rotavirus	2897	2898	2899	2900	2901	2902	VARICELLAFINDATE5AGE
Hepatiitti A (HAV)	2912	2913	2914	2915	2916	2917	TBEFINLANDDATE1AGE
Hepatiitti B (HBV)	2760	2761	2762	2763	2764	2765	TBEFINLANDDATE2AGE
Hepatiitti A ja hepatiitti B	2927	2928	2929	2930	2931	2932	TBEFINLANDDATE3AGE
(TBE)	2942	2943	2944	2945	2946	2947	TBEFINLANDDATE4AGE
Influenssa (käytetään, kun influenssarokote on annettu pistoksena; koodia V0037 käytetään, kun influenssarokote on annettu nenän kautta)	2957	2958	2958	2960	2961	2962	TBEFINLANDDATE5AGE
Vesirokko	2835	2836	2837	2838	2839	2840	HEPATITISABFINLANDDATE1AGE
Muu 3098	2850	2851	2852	2853	2854	2855	HEPATITISABFINLANDDATE2AGE
Muu 3099	2865	2866	2867	2868	2869	2870	HEPATITISABFINLANDDATE3AGE
Muu 3100	2972	2973	2974	2975	2976	2977	HEPATITISABFINLANDDATE4AGE
							HEPATITISABFINLANDDATE5AGE
							OTHER1FINLANDDATE1AGE
							OTHER1FINLANDDATE2AGE
							OTHER1FINLANDDATE3AGE
							OTHER1FINLANDDATE4AGE
							OTHER1FINLANDDATE5AGE
							INFLUENZAFINLAND1AGE
							INFLUENZAFINLAND2AGE
							INFLUENZAFINLAND3AGE
							INFLUENZAFINLAND4AGE
							INFLUENZAFINLAND5AGE

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

OTHERDYNSWEVACCINATIONCODE1_1
OTHERDYNSWEVACCINATIONCODE2_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)					
2575	2576	2570	2571	2572	2573	2577	2578	years	2579	months	2580	years	2581	months
								years		months		years		months
								years		months		years		months
								years		months		years		months

Add

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)	Diagnosis: ICD-10 Code
<input type="text" value="2583"/> <input type="text" value="2584"/> <input type="text" value="2585"/>	Illness Symptoms Codes1_1 <input type="text" value="2586"/> <input type="text" value="2587"/> <input type="text" value="2588"/>	IllnessNoSymptoms1_1 <input type="checkbox"/> No Symptoms 4181	<input type="text" value="2741"/> IllnessDiagnosisCode1_1 <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider 2740
DateIllnessAppearedAge1_1 <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> No Symptoms	IllnessFever1_1 <input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="button" value="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)
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3751	3744 3745	3746 3747

ChronicIllnessICD10Code1_1

AGEDIAGNOSISCHRONICILLNESS1_1

AGECHRONICILLNESSREMISSION1_1

Add

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.

No Yes 2595 MedicationGivenToChildOrNot

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	<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 for medication above 3118	<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

- 4113 - MedicationName1_1
- 2596 - MedicationCode1_1
- 2597 - MedicationReasonCode1_1
- 3111 - MedNonTreatmentReason1_1
- 3118 - AddlReasonForMedAbove1_1
- 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	2612 <input type="checkbox"/> ER visit only <input type="checkbox"/>	2614	<input type="radio"/> No <input type="radio"/> Yes
2610	Outpatient treatment		HaveRightsToViewMedCharts1_1
2611	2602	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
	<input type="checkbox"/> ER visit only <input type="checkbox"/>		<input type="radio"/> No <input type="radio"/> Yes
	Outpatient treatment		
	NumNightsHospitalized1_1 ERVisitOnly1_1 OutpatientTreatment1_1		
Add			

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
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TEDDY

The Environmental Determinants of Diabetes in the Young

Teddy Calendar for 6-12 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		Visit Location Code	
TEDDY Staff Code			

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	4269 years 4270 months 4267 years 4268 months 4275 years 4276 months	4271 years 4272 months 4273 years	AllergySymptomsCode11_1 AllergySymptomsCode12_1	4274 RecommByHealthCareProvider1_1 <input type="radio"/> No <input type="radio"/> Yes	4266 <input type="radio"/> Skin test DiagnosisType1_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	years months	years months	AllergySymptomsCode21_1	RecommByHealthCareProvider2_1 <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Skin test <input type="radio"/> Blood test DiagnosisType2_1 <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	years months	years months	AllergySymptomsCode31_1	RecommByHealthCareProvider3_1 <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Skin test <input type="radio"/> Blood test DiagnosisType3_1 <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 CowMilkAvoidSuggestedByProvide
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 CerealAvoidSuggestedByProvider
c. Gluten-free diet due to celiac disease in the child	4301 years 4302 months	4303 years 4304 months	<input type="radio"/> No <input type="radio"/> Yes 4295 GlutenfreeDietProvider
d. Vegetarian Diet What types of food does the child eat on this vegetarian diet? (Mark all that apply)	4305 years 4306 months VegetarianDietStartedYrs VegetarianDietStartedMon	4307 years 4308 months VegetarianDietStoppedYrs VegetarianDietStoppedMon	<input type="radio"/> No <input type="radio"/> Yes 4296 VegeDietSuggestedByHealthCare
<input type="checkbox"/> Plant products TypeOfFoodChildHasVe_Plantproducts <input type="checkbox"/> Milk and milk products 4297 <input type="checkbox"/> Eggs TypeOfFoodChildHasVe_Eggs <input type="checkbox"/> Fish TypeOfFoodChildHasVe_Fish			

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 OtherDietRecommendedbyprovi1_1
<input type="button" value="Add"/> OtherDietSpecify1_1 OtherDietCode1_1			

3. Weight and Height - Fill in weight and height every time the child is weighed and measured by a health care provider. (Encourage the parent to bring in the child's "chart" and take the numbers from there.)

Date of Measurement		Weight in Pounds	Weight in Ounces	Weight in Kgs	Height in Feet	Height in Inches	Height in Cms
4324	4325	4327	4328	4700		4329	4701
4326							
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

ChildsVacinatCardChecked

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			Date of vaccine			Date of vaccine			Date of vaccine			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)	Rokotuspäivä (PV/KK/VVVV)	Rokotuspäivä (PV/KK/VVVV)	Rokotuspäivä (PV/KK/VVVV)	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)			Datum der Impfung (TT/MMM/JJJJ)			Datum der Impfung (TT/MMM/JJJJ)			Datum der Impfung (TT/MMM/JJJJ)			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			Datum der Impfung			Datum der Impfung			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)	Datum för vaccination (DD/MMM/ÅÅÅÅ)	Datum för vaccination (DD/MMM/ÅÅÅÅ)	Datum för vaccination (DD/MMM/ÅÅÅÅ)	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	4784 4785 4786	4787 4788
Kikhosta		4789 4790 4791	4792 4793 4794	4795 4796 4797	4798 4799 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 4897 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	Datum för vaccination	Datum för vaccination	Datum för vaccination	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)	Diagnosis: ICD-10 Code
<input type="text" value="4542"/> <input type="text" value="4543"/> <input type="text" value="4547"/> <input type="text" value="4548"/> <input type="text" value="4549"/> <input type="text" value="4550"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text" value="4546"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> No Symptoms	<input type="radio"/> No <input type="radio"/> Yes, Measured <input type="radio"/> Yes, Not Measured	<input type="text"/> <input type="radio"/> Diagnosed by parent <input type="radio"/> Diagnosed by health care provider

Date Illness first appeared

IllnessSymptomCode1
 IllnessSymptomCode2
 IllnessSymptomCode3

IllnessFever

IllnessDiagnosisCode

IllnessDiagnosis

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

ChronicIllnessICD10Code1_1

4554	4555

Date of Diagnosis of Chronic Illness

4556	4557

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.

No (Continue to the next section)
 Yes (fill in the table)
 4569
 MedicationGivenToChildOrNot

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 <input type="checkbox"/> Additional reason 4565 for medication above	<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 4564 4559 <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"/>				

- MedicationName1_1
- MedicationCode1_1
- MedicationReasonCode1_1
- MedNonTreatmentReason1_1
- AddlReasonForMedAbove1_1
- NumDaysMedication1_1
- MedicationOngoingOrNot1_1
- 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		*					
Person(s) Interviewed	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other Primary Caretaker <input type="checkbox"/> 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? BabyBorn_WeeksBeforeDueDate

442

If after, how many days after the due date? BabyBorn_DaysAfterDueDate

443

(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? HowWasBabyDelievered_ 411

Normal vaginal NormalVagina Breech Breech

Caesarian section Caseariansec Vacuum extraction VacuumExtrac

Forceps Extraction ForcepsExtra Other other

Code

651 BabyDeliveredCode1_1

Other Codes

1925

Add

642

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	ICD- 10 Code <input type="text" value="439"/> OtherConditionCode More ICD-10 Codes <input type="text" value="1876"/> MoreOtherCodes1_1 <input type="text"/> <input type="button" value="Add"/>	437 OtherCondition <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't Know	

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
<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"/>

ChildHospFromDynDay1_1 **ChildHospUntilDynDay1_1**

ChildEverHospDynCode1_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

MedicationName1_1

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"/>

MedicationStillTaking1_1 **MedicationAsNeeded1_1**

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?* 473

BabyGivenDonatedBreastMilk

No Yes

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.* 478

No Yes

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 <input type="radio"/> Powder <input type="radio"/> Liquid concentrate	<input type="text" value="482"/>	<input type="text" value="483"/>	<input type="checkbox"/>	
	<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"/>
	<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="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"/>					

Liquid_PowderCode

Powder_Liquid

480

InfantFormula_StartAge
InfantFormula_StopAge

484

InfantFormula_StillReceiving

WhyChangedFormulaBrandCode
ChangdFormulaBrandTypeCode2

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

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

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"> <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_StillOnDiet CowsMilkAvoid_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"/> _StillOnDiet _AgeStarted	597 <input type="checkbox"/> Still on diet <input type="text" value="596"/> _StoppedAge _StillOnDiet	<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 608 VegeDiet_SuggestedByHealthCare
e. Kosher Diet <input type="checkbox"/> Not on diet 610 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 614 _SuggestedByHealthCare
f. Other Diet: Code <input type="text" value="637"/> <input type="checkbox"/> Not on diet 615 OtherDietCode1_1 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 619 SuggestedByHealthCare

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? <small>ParentLifeExpContinuousLifeEvent</small>
<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	<input type="checkbox"/> Yes 2080
<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

Specify other events 21) Code ParentsLifeOtherEvents1

Specify other events 22) Code ParentLife_OtherEvents_Code2

Specify other events 34) Code _Code3

Specify other events 35) Code _Code4

Specify other events 36) Code _Code5

Specify other events 37) Code _Code6

Specify other events 38) Code _Code7

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

Specify other events 32) Code

ChildLifeExpOtherEventsCode1

Specify other events 33)	Code	<input type="text" value="721"/>
Specify other events 39)	Code	<input type="text" value="3901"/>
Specify other events 40)	Code	<input type="text" value="3902"/>
Specify other events 41)	Code	<input type="text" value="3903"/>
Specify other events 42)	Code	<input type="text" value="3904"/>
Specify other events 43)	Code	<input type="text" value="3905"/>

ChildLife_OtherEvents_Code2
_Code3
_Code4
_Code5
_Code6
_Code7