Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

A. VISIT INFORMATION

1. Visit Date: __ __ / __ __ / __ __ __ __ (MM DD YYYY)

B. ELIGIBILITY

1. Does the participant have at least one blood relative (living or deceased) with type 1 diabetes (**T1D**)? Y N
2. Has the participant been diagnosed with type 1 diabetes (**T1D**)? Y N
3. Has the participant ever used insulin (current or previous) or any oral hypoglycemic drugs such as sulfonylureas, metformin, thiazolidinediones, alpha-glucosidase inhibitors or other glucose lowering drugs? Y N
   a. If YES, specify: _____
4. Is the participant currently using immunosuppressive or immunomodulatory therapies, or systemic glucocorticoids? Y N
5. Does the participant have known severe active diseases, and/or diseases which are likely to limit life expectancy or lead to use of immunosuppressive or immunomodulatory therapies during the course of the study? Y N
6. Has the participant ever tested positive for pancreas or diabetes autoantibodies? Y N
7. Is the participant currently pregnant? Y N

If the participant answered NO to question 1 <u>OR</u> YES to any of questions 2-7, he/she is <u>ineligible</u> to participate in the study. If ineligible:

- **DO NOT complete the remainder of this form. Do not send to the Coordinating Center.**
- **Complete a Diabetes Onset Form (NH08) if the answer to question 2 is YES**

C. INFORMED CONSENT AND PERMISSIONS

1. Date participant signed the Informed Consent Form: __ __ / __ __ / __ __ __ __ (MM DD YYYY)

D. MEDICAL HISTORY

Has the participant been told by a physician that he/she has any of the following conditions?

Condition/Disease	a. Ever been told?	If YES 1. Within the last year?
1. Asthma	Y N	Y N
2. High blood pressure	Y N	Y N
3. High cholesterol	Y N	Y N

Initials of Person Completing this Form: _____ Date: _____

Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

4. Ulcer (stomach or duodenal)	Y N	Y N
5. Hepatitis/Liver disease	Y N	Y N
6. Cancer	Y N	Y N
7. Celiac Disease	Y N	Y N
8. Colitis or Colon Problems	Y N	Y N
9. Addison's Disease	Y N	Y N
10. Vitiligo	Y N	Y N
11. Thyroid disease	Y N	Y N
12. Congenital heart disease or heart problems	Y N	Y N
13. Infectious mononucleosis	Y N	Y N
14. Epilepsy, convulsions, or seizures	Y N	Y N
15. Pernicious anemia	Y N	Y N
16. Psoriasis	Y N	Y N
17. Alopecia (hair loss)	Y N	Y N
18. Rheumatologic disease (e.g. lupus, rheumatoid arthritis, etc.)	Y N	Y N
19. Allergies	Y N	Y N

b. If YES, specify: _____

E. CURRENT MEDICATIONS

Is the participant currently taking any of the following medications?

1. Steroids	Y N
a. If YES, specify:	_____
2. Potassium Depleting Diuretics	Y N
a. If YES, specify:	_____
3. Beta Blockers	Y N
a. If YES, specify:	_____
4. Immunosuppressives or immunomodulatory therapies	Y N
a. If YES, specify:	_____
5. Niacin	Y N
6. Diphenylhydantoin (Dilantin)	Y N

Initials of Person Completing this Form: _____ Date: _____

Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

F. HEIGHT, WEIGHT AND VITAL SIGNS

Collect the following physical assessments:

Note: *The participant should rest for 5 minutes before these assessments are performed*

1. Seated arm blood pressure: __ __ __ mm Hg / __ __ __ mm Hg (Systolic / Diastolic)
2. Seated heart rate: __ __ __ Beats/minute
3. Seated respiratory rate**:** __ __ __ Breaths/minute
4. Weight: __ __ __ .__ kg or __ __ __ . __ __ lbs
5. Height *(If participant <18 years use a stadiometer if available):* __ __ __ . __ cm or __ __ . __ __ in

H. LABORATORY TESTS

1. Date of sample collection: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)

Laboratory Tests	a. Sample collected?	Comment
2. Autoantibodies	Y N	_____
3. HLA	Y N	_____
4. HbA1c	Y N	_____
5. OGTT	Y N	_____

Complete the appropriate Specimen Transmittal Forms and file copies with the Source Documentation.

Initials of Person Completing this Form: _____ Date: _____

Site Number: ___ ___ ___ ___ Participant ID: ___ ___ ___ ___ ___ ___ 1st three letters of First Name: ___ ___ ___

I. COLLECTION OF MECHANISTIC SAMPLES FOR REPOSITING

1. Date of mechanistic sample collection: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)

Sample	a. Sample collected?	Comment
2. Whole Blood for RNA	Y N	_____
3. Whole Blood for Cells	Y N	_____
4. Plasma (*from blood for cells)*	Y N	_____
5. Serum for Proteomics	Y N	_____
6. Whole Blood for DNA	Y N	_____

Complete the appropriate Specimen Transmittal Forms and file copies with the Source Documentation.

Signature of Person Completing this Form _____

Date form completed: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)