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

Complete at the first follow-up visit for participants who were previously enrolled in the Type 1 Diabetes Prevention Trial (DPT-1).

## A. VISIT INFORMATION

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

## B. ELIGIBILITY

1. Has the participant been diagnosed with type 1 diabetes (**T1D**)? Y N
2. Is the participant currently pregnant? Y N

**If the participant answered YES to question 1 OR question 2, he/she is ineligible to participate in the study. If ineligible, DO NOT fill out the remainder of this form.**

## C. INFORMED CONSENT AND PERMISSIONS

1. Date the participant signed the Informed Consent Form: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)
2. Did the participant give permission for blood samples to be stored for **future** testing as described in the Phase 3 Informed Consent Form? Y N

## D. PARTICIPANT'S PERSONAL INFORMATION

1. Date of Birth: __ __ / __ __ / __ __ __ __ (MM / DD / YYYY)
2. Sex of Participant: ☐ 1 M ☐ 2 F
3. Ethnicity of participant (*check one*):
   ☐1 Hispanic or Latino ☐2 Not Hispanic or Latino ☐3 Unknown
4. Race of Participant (*check all that apply*):
   a. ☐1 American Indian/Alaskan Native b. ☐1 Asian c. ☐1 Black/African American
   d. ☐1 Native Hawaiian/Other Pacific Islander e. ☐1 White f. ☐1 Unknown/Not Reported
   g. ☐1 Refused
5. Record the DPT-1 participant ID *(if known):* ___ ___ ___ ___ ___ ___ ___

Initials of Person Completing this Form: _____ Date: _____

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

## E. FAMILY HISTORY INFORMATION

1. How many of the participant's blood relatives have **type 1 diabetes** (including deceased relatives)? ___ ___

*Provide information for up to 8 of the participant's most closely related blood relatives with type 1 diabetes.*

***Use the letter codes below to indicate the type of relative:***

**P**=Parent **IT**=Identical Twin **FS**=Brother/Sister **AU**=Aunt/Uncle **C**=Cousin **CH**=Child
**GP**=Grandparent **NT**=Non-identical Twin **HS**=Half Brother/Sister **N**=Niece/Nephew **HC**=Half-Cousin

| 2. Relative with Type 1 Diabetes | 3. Sex of Relative | 4. Current Age of Relative | 5. Age of Diabetes Onset in Relative | 6. Age Relative Started Insulin | |
|---|---|---|---|---|---|
| *See code above* | *Check One* | *Age in Years* | *Age in Years* | *Age in Years* | *Comments* |
| a. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| b. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| c. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| d. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| e. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| f. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| g. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |
| h. ___ ___ | ☐1 Male ☐2 Female | ___ ___ | ___ ___ | ___ ___ | _____ |

## F. 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? | b. 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 |
| 4. Ulcer (stomach or duodenal) | Y N | Y N |
| 5. Hepatitis/Liver disease | Y N | Y N |

Initials of Person Completing this Form: _____ Date: _____

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

## F. MEDICAL HISTORY (cont.)

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

| Condition/Disease | a. Ever been told? | b. Within the last year? |
|---|---|---|
| 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 |
| c. If YES, specify: | _____ | |
| 20. Diseases likely to limit life expectancy or lead to use of immunosuppressive/immunomodulatory therapies | Y N | Y N |

## G. CURRENT MEDICATIONS

Is the participant currently taking any of the following medications?

1. Steroids or glucocorticoids Y N
   a. If YES, specify: _____
2. Potassium Depleting Diuretics Y N
   a. If YES, specify: _____

Initials of Person Completing this Form: _____ Date: _____

| | | |
|---|---|---|
| 3. Beta Blockers | Y | N |
| a. If YES, specify: | _____ | |
| 4. Immunosuppressive or immunomodulatory therapies | Y | N |
| a. If YES, specify: | _____ | |
| 5. Niacin | Y | N |
| 6. Diphenylhydantoin (Dilantin) | Y | N |
| 7. Meglitinides | Y | N |
| 8. Metformin | Y | N |
| 9. Thiazolidinediones | Y | N |
| 10. Alpha-glucosidase inhibitors | Y | N |
| 11. Other glucose lowering agents | Y | N |

## H. 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 (Systolic) / __ __ __ mm Hg (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 |

Initials of Person Completing this Form: _____ Date: _____

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

## I. LABORATORY TESTS

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

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

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

## J. COLLECTION OF MECHANISTIC SAMPLES FOR REPOSITING

*(This section is **ONLY** for use by Regional Clinical Centers)*

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

| Samples Collected | 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 place copies with the Source Documentation.**

**Signature of Person Completing this Form** _____

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