Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ First 3 Letters of First Name: __ __ __

A copy of this form will be given to the participant at the end of the Baseline Visit. The participant should be allowed to take this copy home with him/her (if desired), since some of the questions may require information from other family members that may not be immediately available to the participant. The official form will be completed either over the phone, or at the next scheduled clinic visit. The participant should bring the copy back with him/her to the next clinic visit to aid completion of the official form.

A. FORM COMPLETION INFORMATION

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

Instructions:
Questions on the pages of this form will be about your family history. Please answer all questions about your birth or natural parents, brothers or sisters (full or half) and any offspring that you might have. Please also include family members who are no longer living. Please answer these questions to the best of your knowledge.

B. BIRTH MOTHER

1. Was your mother ever diagnosed with Type 1 diabetes mellitus? Y N

2. Was your mother ever diagnosed with any other autoimmune diseases? Y N

IF YES,

Indicate which disease(s) *(check all that apply):*

a.	☐ 1	Addison's Disease	f.	☐ 1	Hypogonadism or premature menopause
b.	☐ 1	Alopecia	g.	☐ 1	Hypoparathyroidism
c.	☐ 1	Celiac Disease (gluten allergy or Celiac Sprue)	h.	☐ 1	Pernicious anemia
d.	☐ 1	Grave's Disease (hyperthyroidism)	i.	☐ 1	Vitiligo
e.	☐ 1	Hashimoto's thyroiditis (goiter) or Hypothyroidism	j.	☐ 1	Other autoimmune disease

3. Is your mother currently alive? Y N

4. What is your mother's current age in years *(or age at death if deceased)*? __ __ __

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ First 3 Letters of First Name: __ __ __

C. BIRTH FATHER

1. Was your father ever diagnosed with Type 1 diabetes mellitus? Y N

2. Was your father ever diagnosed with any other autoimmune diseases? Y N

IF YES,

Indicate which disease(s) *(check all that apply):*

a.	☐ 1	Addison's Disease	f.	☐ 1	Hypogonadism or premature menopause
b.	☐ 1	Alopecia	g.	☐ 1	Hypoparathyroidism
c.	☐ 1	Celiac Disease (gluten allergy or Celiac Sprue)	h.	☐ 1	Pernicious anemia
d.	☐ 1	Grave's Disease (hyperthyroidism)	i.	☐ 1	Vitiligo
e.	☐ 1	Hashimoto's thyroiditis (goiter) or Hypothyroidism	j.	☐ 1	Other autoimmune disease

3. Is your father currently alive? Y N

4. What is your father's current age in years *(or age at death if deceased)*? __ __ __

D. BROTHERS AND SISTERS

1. How many full and half brothers and sisters do you have (both living and deceased)? __ __
Do <u>not</u> include adopted, foster, or step brothers and sisters.

If none, **STOP** and continue to **Section D**

If you have any brothers and sisters, please complete sub-form **MMF05S** (attached).

E. CHILDREN

1. How many children have you had (both living and deceased)? *Since this study involves genetics, we are only interested in birth children, not in adopted, foster, or stepchildren.* __ __

If none, **STOP**

If you have any children, please complete sub-form **MMF05C** (attached).

Initials (first, middle, last) of person completing this form: __ __ __ (F M L)

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

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site Number: _ _ _ _ Screening ID: _ _ _ _ _ - _ _ First 3 Letters of First Name: _ _ _

This sub-form should only be completed for participants that have siblings. Additional copies of the second page of this form can be attached if the participant has more siblings than space provided.

A. BROTHERS AND SISTERS

Use the following chart to record information on each of your siblings (both living and deceased).

	Start Here ⇓ 1	2	3	4	5	6*
1. Sibling number:						
2. First and last initials:	_ _	_ _	_ _	_ _	_ _	_ _
3. Sex (Male/Female):	M F	M F	M F	M F	M F	M F
4. Did he/she have						
a. the same birth mother as you?	Y N	Y N	Y N	Y N	Y N	Y N
b. the same birth father as you?	Y N	Y N	Y N	Y N	Y N	Y N
5. Was he/she ever diagnosed with Type 1 diabetes mellitus?	Y N	Y N	Y N	Y N	Y N	Y N
6. Did he/she ever have any autoimmune diseases?	Y N	Y N	Y N	Y N	Y N	Y N
IF YES**,						
a. Indicate disease code from list:	_ _	_ _	_ _	_ _	_ _	_ _
b. Indicate disease code from list:	_ _	_ _	_ _	_ _	_ _	_ _
c. Indicate disease code from list:	_ _	_ _	_ _	_ _	_ _	_ _
7. Is he/she still alive?	Y N	Y N	Y N	Y N	Y N	Y N
8. Age in years (or if deceased, age at death):	___	___	___	___	___	___

*** If additional space is required, continue to next page**

**** If diagnosed with more than one autoimmune disease, indicate up to three by selecting the most recent diagnoses.**

Autoimmune Diseases for Question 6 (a-c):

01 Addison's Disease
02 Alopecia
03 Celiac Disease (gluten allergy or Celiac Sprue)
04 Grave's Disease (hyperthyroidism)
05 Hashimoto's thyroiditis (goiter) or Hypothyroidism
06 Hypogonadism or premature menopause
07 Hypoparathyroidism
08 Pernicious anemia
09 Vitiligo
99 Other autoimmune disease

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ First 3 Letters of First Name: __ __ __

A. BROTHERS AND SISTERS *(additional space, if necessary)*
Use the following chart to record information on each of your siblings, both living and deceased.

Start Here ⇓

1. Sibling number:	__	__	__	__	__	__*
2. First and last initials:	__ __	__ __	__ __	__ __	__ __	__ __
3. Sex (Male/Female):	M F	M F	M F	M F	M F	M F
4. Did he/she have						
a. the same birth mother as you?	Y N	Y N	Y N	Y N	Y N	Y N
b. the same birth father as you?	Y N	Y N	Y N	Y N	Y N	Y N
5. Was he/she ever diagnosed with Type 1 diabetes mellitus?	Y N	Y N	Y N	Y N	Y N	Y N
6. Did he/she ever have any autoimmune diseases?	Y N	Y N	Y N	Y N	Y N	Y N
IF YES**,						
a. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
b. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
c. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
7. Is he/she still alive?	Y N	Y N	Y N	Y N	Y N	Y N
8. Age in years (or if deceased, age at death):	____	____	____	____	____	____

*** If additional space is required, please attach additional copies of this page.**
**** If diagnosed with more than one autoimmune disease, indicate up to three by selecting the most recent diagnoses.**

Autoimmune Diseases for Question 6 (a-c):

01 Addison's Disease
02 Alopecia
03 Celiac Disease (gluten allergy or Celiac Sprue)
04 Grave's Disease (hyperthyroidism)
05 Hashimoto's thyroiditis (goiter) or Hypothyroidism
06 Hypogonadism or premature menopause
07 Hypoparathyroidism
08 Pernicious anemia
09 Vitiligo
99 Other autoimmune disease

Initials (first, middle, last) of person completing this form: __ __ __ (F M L)

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

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ First 3 Letters of First Name: __ __ __

This sub-form should only be completed for participants that have children. If a participant has more children than space provided, additional copies of the second page of this form can be completed and attached.

A. CHILDREN

Use the following chart to record information on each of the children you have had (both living and deceased).

Start Here ⇓

1. Child number:	1	2	3	4	5	6*
2. First and last initials:	__ __	__ __	__ __	__ __	__ __	__ __
3. Sex (Male/Female):	M F	M F	M F	M F	M F	M F
4. Was he/she ever diagnosed with Type 1 diabetes mellitus?	Y N	Y N	Y N	Y N	Y N	Y N
5. Did he/she ever have any autoimmune diseases?	Y N	Y N	Y N	Y N	Y N	Y N
IF YES**,						
a. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
b. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
c. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
6. Is he/she still alive?	Y N	Y N	Y N	Y N	Y N	Y N
7. Age in years (or if deceased, age at death):	____	____	____	____	____	____

*** If additional space is required, please proceed to next page**

**** If diagnosed with more than one autoimmune disease, indicate up to three by selecting the most recent diagnoses**

Autoimmune Diseases for Question 5 (a-c):

01 Addison's Disease
02 Alopecia
03 Celiac Disease (gluten allergy or Celiac Sprue)
04 Grave's Disease (hyperthyroidism)
05 Hashimoto's thyroiditis (goiter) or Hypothyroidism
06 Hypogonadism or premature menopause
07 Hypoparathyroidism
08 Pernicious anemia
09 Vitiligo
99 Other autoimmune disease

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ First 3 Letters of First Name: __ __ __

A. CHILDREN *(additional space if necessary)*
The following chart provides additional space for you to record information on each of the children you have had.

Start Here ⇓

1. Child number:	__	__	__	__	__	__*
2. First and last initials:	__ __	__ __	__ __	__ __	__ __	__ __
3. Sex (Male/Female):	M F	M F	M F	M F	M F	M F
4. Was he/she ever diagnosed with Type 1 diabetes mellitus?	Y N	Y N	Y N	Y N	Y N	Y N
5. Did he/she ever have any autoimmune diseases?	Y N	Y N	Y N	Y N	Y N	Y N
IF YES**,						
a. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
b. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
c. Indicate disease code from list:	__ __	__ __	__ __	__ __	__ __	__ __
6. Is he/she still alive?	Y N	Y N	Y N	Y N	Y N	Y N
7. Age in years (or if deceased, age at death):	____	____	____	____	____	____

*** If additional space is required, attach additional copies of this page**
**** If diagnosed with more than one autoimmune disease, indicate up to three by selecting the most recent diagnoses**

Autoimmune Diseases for Question 5 (a-c):

01 Addison's Disease
02 Alopecia
03 Celiac Disease (gluten allergy or Celiac Sprue)
04 Grave's Disease (hyperthyroidism)
05 Hashimoto's thyroiditis (goiter) or Hypothyroidism
06 Hypogonadism or premature menopause
07 Hypoparathyroidism
08 Pernicious anemia
09 Vitiligo
99 Other autoimmune disease

Initials (first, middle, last) of person completing this form: __ __ __ (F M L)

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

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*