Site Number: __ __ __ __ Screening ID: __ __ __ __ - __ Participant Letters: __ __ __

Complete this form during the Baseline Visit (Week 0).

A. VISIT INFORMATION

1. Visit Date: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
2. Did visit occur at a site other than the primary study site? Y N
   If YES,
   a. Record Site Number for reimbursement: __ __ __ __

***NOTE**: Site Number **must** correspond to a TrialNet Clinical Center, Affiliate, or Participating Physician*

3. On the intervention consent form, was permission given for genetic samples of the participant's blood to be stored? Y N
4. On the intervention consent form, was permission given for samples of the participant's blood to be stored for other tests? Y N

B. DIABETES HISTORY

1. Date of diagnosis of type 1 diabetes: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
2. Was your initial diagnosis based on *(check one):*
   - ☐1 Random blood glucose check (incidental to other medical condition)
   - ☐2 Routine screening for diabetes without presence of symptoms
   - ☐3 Formal testing for diabetes (OGTT)
   - ☐4 Symptoms of diabetes
3. Which of the following symptoms did you have at the time of diagnosis? *(check all that apply)*
   - a. ☐1 Increased thirst
   - b. ☐1 Weight loss
   - c. ☐1 Increased eating
   - d. ☐1 Frequent urination
   - e. ☐1 Frequent infections
   - f. ☐1 No symptoms
4. Which of the following results did you have at the time of diagnosis? *(check all that apply) (if unknown, write "*")*
   - a. ☐1 Urine ketones
   - b. ☐1 Serum ketones
   - c. ☐1 Diabetic Ketoacidosis (DKA)
5. Were you admitted to a hospital during the diagnosis period? Y N
   If YES,
   a. Were you admitted to an Intensive Care Unit (ICU) while in the hospital? Y N
6. Most recent HbA1c: *(if unknown, write "*")* __ __. __ %
   a. If known, record date HbA1c was measured: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
7. Have you ever experienced Diabetic Ketoacidosis? *(if unknown, write "*")* Y N

C. AUTOIMMUNE DISEASE HISTORY

1. Have you ever been diagnosed with an autoimmune disease(s)? Y N
   If YES,
   Record below the code that corresponds with the autoimmune disease(s) you have been diagnosed with: *(see table on page 2)*
   - a. __ __ If OTHER, 1) Specify: _____
   - b. __ __ If OTHER, 1) Specify: _____
   - c. __ __ If OTHER, 1) Specify: _____

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).*

Autoimmune Diseases:

01 Addison's Disease (Adrenal Insufficiency)
02 Alopecia
03 Celiac Disease (Gluten Allergy or Celiac Sprue)
04 Grave's Disease (Hyperthyroidism)
05 Immune Thyroid Disease
06 Rheumatologic Disease
07 Inflammatory Bowel Disease
08 Hypogonadism or Premature Menopause
09 Hypoparathyroidism
10 Pernicious Anemia
11 Vitiligo
12 Psoriasis
13 Lupus
14 Multiple Sclerosis
99 Other Autoimmune Disease

D. MEDICAL HISTORY

1. Have you ever been hospitalized other than for diabetes? Y N
   If YES,
   a. What for? _____

2. Have you had any surgery? Y N
   If YES,
   a. Specify: _____

Has a physician ever told you that you have any of the following conditions?

Condition/Disease	
3. Asthma	Y N
4. High blood pressure	Y N
5. Hepatitis	Y N
6. Cancer	Y N
7. Congenital heart disease or heart problems	Y N
8. Infectious mononucleosis	Y N
9. Leukopenia and/or Neutropenia	Y N
10. Allergies	Y N
11. Frequent other infections	Y N
If YES, a. Specify: _____	
12. Other	Y N
If OTHER, a. Specify: _____	

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).*

E. VACCINATION HISTORY

Have you had any of the following vaccinations? *(if unknown, write "*")*

Vaccination		If YES, a. Date of most recent vaccination given
1. DTP vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
2. Tetanus vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
3. Live flu vaccination (e.g. nasal dose)?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
4. BCG vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
5. Pneumococcus vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
6. Hepatitis A vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
7. Hepatitis B vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
8. MMR vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
9. Varicella (chickenpox) vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
10. H. influenza vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
11. Live polio vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
12. Meningococcal meningitis vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
13. Vaccinia (smallpox) vaccination?	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)
14. Other	Y N	__ __ / __ __ __ / __ __ __ __ (DAY MONTH YEAR)

If OTHER, b. specify: _____

F. CONCOMITANT MEDICATIONS

1. Are there any changes since the Screening Visit in medications/supplements that you are taking other than insulin? Y N

   If YES,

   a. Are you taking or have you taken any NEW medications/supplements since the Screening Visit? Y N

      If YES, list NEW medications/supplements:

      1) _____
      2) _____
      3) _____
      4) _____
      5) _____

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).*

F. CONCOMITANT MEDICATIONS (CONTINUED)

b. Have you DISCONTINUED the use of any medications/supplements since the Screening Visit? Y N

If YES, list DISCONTINUED medications/supplements:

1) _____
2) _____
3) _____
4) _____
5) _____

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

Date form completed: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

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).*