



NIP DIABETES PILOT TRIAL
PREGNANT WOMAN ENROLLMENT FORM

Form NPP03

21Sep2006 (v1.0)

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Site Number: [ ]

Screening ID: [ ] - [ ]

Participant Letters: [ ]

Study Coordinator completes this form after the Pregnant Woman is randomized.

A. VISIT INFORMATION

1. Date of visit (e.g. 05/Sep/2006):

[ ] / [ ] / [ ]
DAY MONTH YEAR

2. Week of pregnancy:

[ ] weeks

3. Date of randomization:

[ ] / [ ] / [ ]
DAY MONTH YEAR

4. Randomization color (check one):

[ ] 1 Gray [ ] 2 Yellow [ ] 3 Red [ ] 4 Orange

B. MEDICAL HISTORY

1. What was her weight prior to this pregnancy?

[ ] lb or [ ] kg

2. Expected date of delivery:

[ ] / [ ] / [ ]
DAY MONTH YEAR

3. Has a physician ever told her that she has any of the following conditions?

Condition/Disease:

Ever had?

1) If YES, within last year?

Cardiovascular

a. High blood pressure

[ ] Y [ ] N [ ] Y [ ] N

b. High cholesterol

[ ] Y [ ] N [ ] Y [ ] N

c. Congenital heart disease or heart problems

[ ] Y [ ] N [ ] Y [ ] N

Respiratory

d. Asthma

[ ] Y [ ] N [ ] Y [ ] N

Gastrointestinal

e. Ulcer (stomach or duodenal)

[ ] Y [ ] N [ ] Y [ ] N

f. Gallstones, disease or surgery of the gallbladder

[ ] Y [ ] N [ ] Y [ ] N

g. Hepatitis/Liver disease

[ ] Y [ ] N [ ] Y [ ] N

h. Colitis or colon problems

[ ] Y [ ] N [ ] Y [ ] N

Neurologic

i. Epilepsy, convulsions or seizures

[ ] Y [ ] N [ ] Y [ ] N

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).



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**B. MEDICAL HISTORY (CONTINUED)**

Condition/Disease: Ever had? 1) If YES, within last year?

**Endocrine**

j. Thyroid disease

Y	N	Y	N
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**Infections**

k. Infectious mononucleosis

Y	N	Y	N
---	---	---	---

l. Frequent urinary tract infections

Y	N	Y	N
---	---	---	---

**Rheumatologic/Autoimmune**

m. Pernicious anemia

Y	N	Y	N
---	---	---	---

n. Alopecia

Y	N	Y	N
---	---	---	---

o. Psoriasis

Y	N	Y	N
---	---	---	---

p. Celiac Sprue

Y	N	Y	N
---	---	---	---

q. Gout

Y	N	Y	N
---	---	---	---

r. Rheumatologic disease

Y	N	Y	N
---	---	---	---

2) If YES, specify:

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**Hematologic/Oncologic**

s. Cancer

Y	N	Y	N
---	---	---	---

2) If YES, specify:

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**Other**

t. Medication allergies

Y	N	Y	N
---	---	---	---

u. Seasonal allergies

Y	N	Y	N
---	---	---	---

v. Other:

Y	N	Y	N
---	---	---	---

2) If OTHER, describe:

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