

Site Number: _____ Screening ID: _____ - ____ Participant Letters: _____

INSTRUCTIONS:

- Complete this form at the following study visits: Pregnant Screening/Enrollment Visit, Infant Screening Visit, 3, 6, 9, and 12 Months Old Visits.
- Section A completed by Study Personnel.
- Section B completed by the mother if she entered the study when pregnant (Entry A) or is currently breastfeeding her baby.
- Study Personnel will collect the completed form from you before leaving, review your responses, and initial and date the form.
- If you have any questions about this form, please ask Study Personnel.

TO BE COMPLETED BY STUDY PERSONNEL:

A. VISIT INFORMATION

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

___	/	___	/	___
DAY		MONTH		YEAR

2. Vitamin and dietary supplements for (check one):

<input type="checkbox"/> 1	Pregnant Woman	<input type="checkbox"/> 2	Nursing Mother
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3. For which visit is this form being completed (check one):

<input type="checkbox"/> 91	Pregnancy Screening / Enrollment	<input type="checkbox"/> 94	Infant Enrollment/ 6 Months Old Visit	<input type="checkbox"/> 6	6 Months Old
<input type="checkbox"/> 1	Infant Screening	<input type="checkbox"/> 95	Entry A Infant Screening /Infant Enrollment	<input type="checkbox"/> 9	9 Months Old
<input type="checkbox"/> 93	Infant Enrollment combined with 3 Months Old Visit	<input type="checkbox"/> 3	3 Months Old	<input type="checkbox"/> 12	12 Months Old

TO BE COMPLETED BY MOTHER:

B. MOTHER VITAMIN AND DIETARY SUPPLEMENTS

1. How often did you take the following vitamins, minerals, or dietary supplements in the last 3 months (check one):

Did not take	A few days per month	1-3 days per week	4-6 days per week	Every day
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a. Multiple vitamins

1) Prenatal vitamin	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2) Multivitamin (e.g. One-a-Day)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3) Multivitamin with antioxidant (e.g. Oncovite)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 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.)*



**NIP DIABETES PILOT TRIAL
PREGNANT WOMAN/NURSING MOTHER
VITAMIN AND DIETARY SUPPLEMENT FORM**

Form NPP20M

15Nov2007(v1.1)

Page 2 of 2

Site Number: _____ Screening ID: _____ - ____ Participant Letters: _____

B. MOTHER VITAMIN AND DIETARY SUPPLEMENTS (CONTINUED)

1. How often did you take the following vitamins, minerals, or dietary supplements in the last 3 months (*check one*):

	A few days per month	1-3 days per week	4-6 days per week	Every day
	Did not take			

b. Single vitamins (*not part of a multiple vitamin*)

1) Vitamin A (<i>not beta-carotene</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2) Beta-carotene	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3) Vitamin C	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4) Vitamin E	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5) Folic acid, folate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6) Calcium, alone or combined with Vitamin D	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7) Tums	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8) Zinc, alone or combined with something else	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9) Iron	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10) Selenium	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11) Fish oil, Omega-3 fatty acids, DHA/EPA	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12) Flax seed oil	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13) Other: _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
14) Other: _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Initials (first, middle, last) of Study Personnel reviewing this form: _____
F M L

Date form completed: _____ / _____ / _____
DAY MONTH YEAR

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