Site Number: Participant ID:
Date of Visit: Participant Letters:
Person Completing Form:

A. MEDICAL HISTORY

1. Have you ever been hospitalized other than for diabetes?   O Yes O No O Unknown
    If YES, what for?

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

Condition/Disease

2. Asthma   O Yes O No O Unknown

3. Leukopenia and/or Neutropenia   O Yes O No O Unknown

4. Allergies   O Yes O No O Unknown

5. Frequent other infections   O Yes O No O Unknown

    If YES, specify:

6. Other   O Yes O No O Unknown

    If OTHER, specify:

    specify:

B. DIABETES HISTORY

1. Date of diagnosis of type 1 diabetes: __ __ / __ __ __ / __ __ __ __
    DAY   MONTH   YEAR

2. Was your initial diagnosis based on *(select all that apply):*
    □ Random blood glucose check (incidental to other medical condition)   □ Formal testing for diabetes (OGTT)
    □ Routine screening for diabetes without presence of symptoms   □ Symptoms of diabetes

3. Which of the following symptoms did you have at the time of diagnosis? *(check all that apply)*
    a. □ Increased thirst   e. □ Frequent infections
    b. □ Weight loss   f. □ Blurred vision
    c. □ Increased eating   g. □ No symptoms
    d. □ Frequent urination

4. Did you have Diabetic Ketoacidosis (DKA) at time of diagnosis?   O Yes O No O Unknown

5. Were you admitted to a hospital during the diagnosis period?   O Yes O No O Unknown
    If YES,
    a. Were you admitted to an Intensive Care Unit (ICU) while in the hospital?   O Yes O No O Unknown

6. Most recent HbA1c: __ __ . __ %

    a. If known, record date HbA1c was measured: __ __ / __ __ __ / __ __ __ __
    DAY   MONTH   YEAR

7. Since diagnosis, have you ever experienced Diabetic Ketoacidosis?   O Yes O No O Unknown

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C. AUTOIMMUNE DISEASE HISTORY

1. Have you ever been diagnosed with an autoimmune disease(s)?   O Yes   O No   O Unknown

If YES,   Date of diagnosis

Disease		Date of diagnosis
Addison's Disease (Adrenal Insufficiency)	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Alopecia	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Celiac Disease (Gluten Allergy or Celiac Sprue)	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Grave's Disease (Hyperthyroidism)	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Hypogonadism or Premature Menopause	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Hypoparathyroidism	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Autoimmune Thyroid Disease (Hypothyroidism or Hashimoto's Disease)	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Inflammatory Bowel Disease	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Lupus	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Multiple Sclerosis	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Pernicious Anemia	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Psoriasis	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Rheumatologic Disease	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Vitiligo	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Other, specify:	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Other, specify:	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR
Other, specify:	O Yes O No O Unknown	__ __ / __ __ __ / __ __ __ __
		DAY MONTH YEAR

Type 1 Diabetes TrialNet

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D. REVIEW OF SYSTEMS

1. Record whether there are any abnormalities in the following systems review

	1) Findings	If ABNORMAL, explain:
a. HEENT	○ Normal ○ Abnormal ○ Not Assessed	
b. Pulmonary	○ Normal ○ Abnormal ○ Not Assessed	
c. Cardiovascular	○ Normal ○ Abnormal ○ Not Assessed	
d. Endocrine (other than T1D)	○ Normal ○ Abnormal ○ Not Assessed	
e. Gastrointestinal	○ Normal ○ Abnormal ○ Not Assessed	
f. Reproductive	○ Normal ○ Abnormal ○ Not Assessed	
g. Musculoskeletal	○ Normal ○ Abnormal ○ Not Assessed	
h. Neurological	○ Normal ○ Abnormal ○ Not Assessed	
i. Integument	○ Normal ○ Abnormal ○ Not Assessed	
j. Other	○ Normal ○ Abnormal ○ Not Assessed	