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

Complete this form during the Screening Visit.

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*

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)	☐3	Formal testing for diabetes (OGTT)
☐2	Routine screening for diabetes without presence of symptoms	☐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	e.	☐1	Frequent infections
b.	☐1	Weight loss	f.	☐1	Blurred vision
c.	☐1	Increased eating	g.	☐1	No symptoms
d.	☐1	Frequent urination			

4. Did you have Diabetic Ketoacidosis (DKA) at time of diagnosis? Y N

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 for the autoimmune disease(s) you have been diagnosed with:
   (see table on page 2)

				2) Was this diagnosed before your diagnosis of diabetes?
a.	__ __	If OTHER, 1) Specify:	_____	Y N
b.	__ __	If OTHER, 1) Specify:	_____	Y N
c.	__ __	If OTHER, 1) Specify:	_____	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).*

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

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. VACCINATION HISTORY

1. To your knowledge, are you (or your child) up to date on your childhood vaccinations? Y N

2. Have you ever received the Tetanus vaccination? Y N

   a. If yes, record date of most recent vaccination: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

E. MEDICAL HISTORY

1. Have you ever been hospitalized other than for diabetes? Y N

   If YES,

   a. What for? _____

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

Condition/Disease	
2. Asthma	Y N
3. Leukopenia and/or Neutropenia	Y N
4. Allergies	Y N
5. Frequent infections	Y N
If YES, a. Specify: _____	
6. Other	Y N
If OTHER, a. Specify: _____	
b. Specify: _____	

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).*