

Site Number: \_\_\_\_\_

Screening ID: \_\_\_\_\_ - \_\_\_\_\_

Participant Letters: \_\_\_\_\_

Complete this form at Baseline and for all regularly scheduled follow-up visits.

## A. VISIT INFORMATION

1. Visit Date:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
DAY MONTH YEAR

2. For which visit is this form being completed? (check one)

- |                                     |                                      |                                      |                                      |
|-------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> 0 Baseline | <input type="checkbox"/> 8 Visit 8   | <input type="checkbox"/> 16 Visit 16 | <input type="checkbox"/> 24 Visit 24 |
| <input type="checkbox"/> 1 Visit 1  | <input type="checkbox"/> 9 Visit 9   | <input type="checkbox"/> 17 Visit 17 | <input type="checkbox"/> 25 Visit 25 |
| <input type="checkbox"/> 2 Visit 2  | <input type="checkbox"/> 10 Visit 10 | <input type="checkbox"/> 18 Visit 18 | <input type="checkbox"/> 26 Visit 26 |
| <input type="checkbox"/> 3 Visit 3  | <input type="checkbox"/> 11 Visit 11 | <input type="checkbox"/> 19 Visit 19 | <input type="checkbox"/> 27 Visit 27 |
| <input type="checkbox"/> 4 Visit 4  | <input type="checkbox"/> 12 Visit 12 | <input type="checkbox"/> 20 Visit 20 | <input type="checkbox"/> 28 Visit 28 |
| <input type="checkbox"/> 5 Visit 5  | <input type="checkbox"/> 13 Visit 13 | <input type="checkbox"/> 21 Visit 21 | <input type="checkbox"/> 29 Visit 29 |
| <input type="checkbox"/> 6 Visit 6  | <input type="checkbox"/> 14 Visit 14 | <input type="checkbox"/> 22 Visit 22 | <input type="checkbox"/> 30 Visit 30 |
| <input type="checkbox"/> 7 Visit 7  | <input type="checkbox"/> 15 Visit 15 | <input type="checkbox"/> 23 Visit 23 | <input type="checkbox"/> 31 Visit 31 |

## B. CONCOMITANT MEDICATIONS

1. Are there any changes since the previous visit in prescription or non-prescription medications or supplements that you are taking other than insulin?

Y N

If the change in medication was due to an *adverse event*,  
complete an Adverse Event Report Form (CTL13) if  $\geq$  Grade 2 severity.

If YES,

a. Are you taking or have you taken any NEW medications or supplements since the last visit?

Y N

If YES, list NEW medications/supplements:

- 1) \_\_\_\_\_  
a) For what? \_\_\_\_\_
- 2) \_\_\_\_\_  
a) For what? \_\_\_\_\_
- 3) \_\_\_\_\_  
a) For what? \_\_\_\_\_
- 4) \_\_\_\_\_  
a) For what? \_\_\_\_\_

b. Have you DISCONTINUED the use of any prescription or non-prescription medications or supplements since the last visit?

Y N

If YES, list DISCONTINUED medications or supplements:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

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).