Participant ID:		Date of Registration:	
Local ID:		Letters:	
Status:			
Site:			

Screening Medical History

* These fields are required in order to SAVE the form

* These fields are required in order to COMPLETE the form

Date of Visit: * ▼ Date

Interviewer User ID: *

A. Medical History

1.) Have you ever been hospitalized? ○ Yes ○ No ○ Unknown

If yes, what for?

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

2.) Asthma ○ Yes ○ No ○ Unknown

3.) Leukopenia and/or neutropenia ○ Yes ○ No ○ Unknown

4.) Allergies ○ Yes ○ No ○ Unknown

5.) Eczema ○ Yes ○ No ○ Unknown

6.) Frequent other infections ○ Yes ○ No ○ Unknown

If yes, specify:

7.) Other ○ Yes ○ No ○ Unknown

If other, specify:

1 ▼

Save Print Close Window

Participant ID:		Date of Registration:	
Local ID:		Letters:	
Status:			
Site:			

Screening Medical History

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Date of Visit: * Date

Interviewer User ID: *

B. Diabetes History

1.) Date of diagnosis of type 1 diabetes:

2.) Was the participant's initial diagnosis based on:

- ☐ Random blood glucose check
- ☐ Formal testing for diabetes (OGTT)
- ☐ Routine screening for diabetes without presence of symptoms
- ☐ Symptoms of Diabetes

3.) Which of the following symptoms did the participant have at the time of diagnosis?

- ☐ Increased thirst
- ☐ Frequent infections
- ☐ Weight loss
- ☐ Blurred vision
- ☐ Increased Eating
- ☐ No symptoms
- ☐ Frequent urination

4.) Did the participant have Diabetic Ketoacidosis (DKA) at time of diagnosis? ○ Yes ○ No ○ Unknown

5.) Was the participant admitted to a hospital during the diagnosis period? ○ Yes ○ No ○ Unknown

If yes, were they admitted to an Intensive Care Unit (ICU) while in the hospital? ○ Yes ○ No ○ Unknown

6.) Most recent HbA1c %

If known, record date HbA1c was measured:

7.) Since diagnosis, has the participant ever experienced Diabetic Ketoacidosis? ○ Yes ○ No ○ Unknown

Participant ID:		Date of Registration:	
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Screening Medical History

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Interviewer User ID: *

B. Autoimmune Disease History

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

If yes:

		Date of Diagnosis
Addison's Disease (Adrenal Insufficiency)	Yes No Unknown	
Alopecia	Yes No Unknown	
Celiac Disease (Gluten Allergy or Celiac Sprue)	Yes No Unknown	
Grave's Disease (Hyperthyroidism)	Yes No Unknown	
Hypogonadism or Premature Menopause	Yes No Unknown	
Hypoparathyroidism	Yes No Unknown	
Autoimmune Thyroid Disease (Hypothyroidism or Hashimoto's Disease)	Yes No Unknown	
Inflammatory Bowel Disease	Yes No Unknown	

Lupus	Yes No Unknown	
Multiple Sclerosis	Yes No Unknown	
Pernicious Anemia	Yes No Unknown	
Psoriasis	Yes No Unknown	
Rheumatologic Disease	Yes No Unknown	
Vitiligo	Yes No Unknown	

Other, Specify | **Date of Diagnosis**

Yes No Unknown

Add

3

Save Print Close Window

Participant ID:		Date of Registration:	
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Status:			
Site:			

Screening Medical History

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Date of Visit: * ▼ Date

Interviewer User ID: *

C. Review of Systems

Record whether there are any abnormalities in the following systems review:

	Findings	If abnormal, explain
a. Psychiatric	○ Normal ○ Abnormal ○ Not Assessed	
b. Neurologic	○ Normal ○ Abnormal ○ Not Assessed	
c. Respiratory	○ Normal ○ Abnormal ○ Not Assessed	
d. Cardiovascular	○ Normal ○ Abnormal ○ Not Assessed	
e. Gastrointestinal	○ Normal ○ Abnormal ○ Not Assessed	
f. Hematopoetic	○ Normal ○ Abnormal ○ Not Assessed	

g. Musculoskeletal	○ Normal ○ Abnormal ○ Not Assessed	
h. Lymphatic	○ Normal ○ Abnormal ○ Not Assessed	
i. Endocrine	○ Normal ○ Abnormal ○ Not Assessed	
j. Genitourinary	○ Normal ○ Abnormal ○ Not Assessed	
k. Dermatologic	○ Normal ○ Abnormal ○ Not Assessed	
l. Constitutional Symptoms (eg fever, weight change, fatigue)	○ Normal ○ Abnormal ○ Not Assessed	
	Findings	**If abnormal, explain**
m. Other	○ Normal ○ Abnormal ○ Not Assessed	

Add

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