

Site Number:  
Date of Visit:  
Person Completing Form:

Participant ID:  
Participant Letters:

**A. MEDICAL HISTORY**

1. Have you ever been hospitalized?  
If YES, what for?

Yes  No  Unknown

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

**Condition/Disease**

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:

specify:

**B. DIABETES HISTORY (Will be Disabled)**

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)
- Routine screening for diabetes without presence of symptoms

- Formal testing for diabetes (OGTT)
- Symptoms of diabetes

3. Which of the following symptoms did you have at the time of diagnosis? (check all that apply)

- a.  Increased thirst
- b.  Weight loss
- c.  Increased eating
- d.  Frequent urination
- e.  Frequent infections
- f.  Blurred vision
- g.  No symptoms

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

Yes  No  Unknown

5. Were you admitted to a hospital during the diagnosis period?

Yes  No  Unknown

If YES,

a. Were you admitted to an Intensive Care Unit (ICU) while in the hospital?

Yes  No  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?

Yes  No  Unknown

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**C. 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

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

Alopecia

Yes  No  Unknown

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

Celiac Disease (Gluten Allergy or Celiac Sprue)

Yes  No  Unknown

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

Grave's Disease (Hyperthyroidism)

Yes  No  Unknown

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

Hypogonadism or Premature Menopause

Yes  No  Unknown

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

Hypoparathyroidism

Yes  No  Unknown

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

Autoimmune Thyroid Disease (Hypothyroidism or Hashimoto's Disease)

Yes  No  Unknown

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

Inflammatory Bowel Disease

Yes  No  Unknown

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

Lupus

Yes  No  Unknown

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

Multiple Sclerosis

Yes  No  Unknown

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

Pernicious Anemia

Yes  No  Unknown

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

Psoriasis

Yes  No  Unknown

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

Rheumatologic Disease

Yes  No  Unknown

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

Vitiligo

Yes  No  Unknown

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

Other, specify:

Yes  No  Unknown

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

Other, specify:

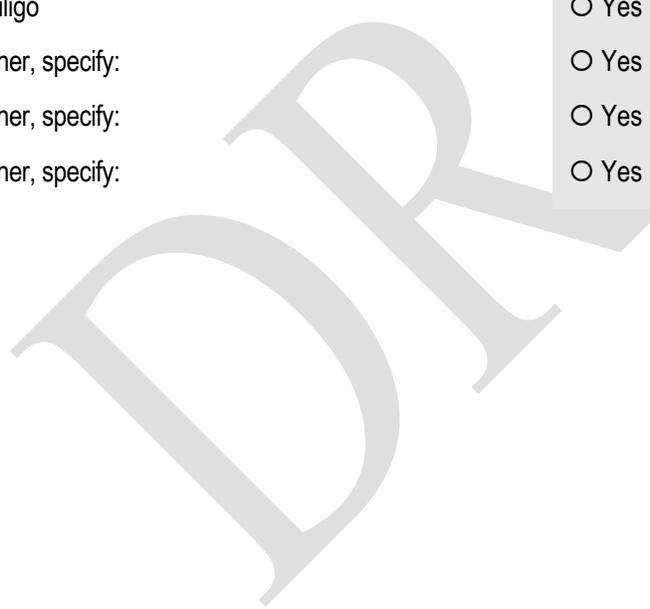
Yes  No  Unknown

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

Other, specify:

Yes  No  Unknown

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



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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. Psychiatric	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
b. Neurologic	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
c. Respiratory	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
d. Cardiovascular	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
e. Gastrointestinal	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
f. Hematopoetic	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
g. Musculoskeletal	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
h. Lymphatic	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
i. Endocrine	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
j. Genitourinary	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
k. Dermatologic	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
l. Constitutional Symptoms (eg fever, weight change, fatigue)	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	
m. Other	<input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Not Assessed	