

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:

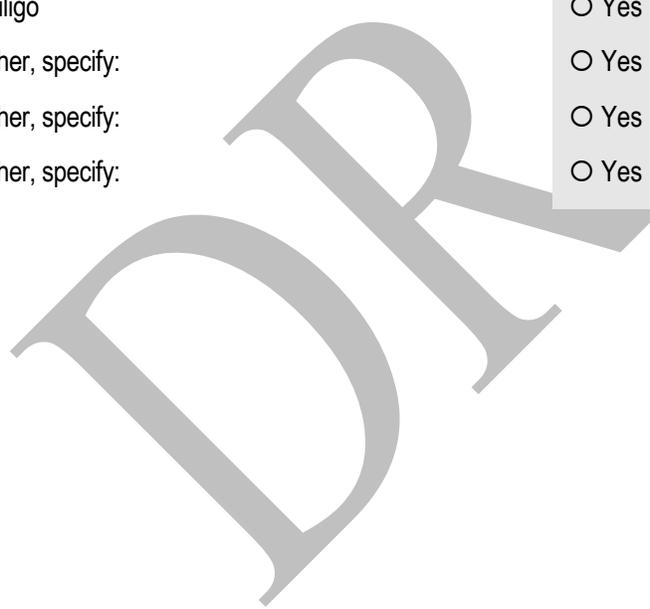
Yes No Unknown

___/___/___
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	