Site Number: Participant ID:
Date of Visit: Participant Letters:
Person Completing Form:

A. MEDICAL HISTORY

1. Has the participant ever been hospitalized other than for diabetes? ○ Yes ○ No ○ Unknown

If YES, what for?

Has a physician ever told the participant that they 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

1. Date of diagnosis of type 1 diabetes: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

2. Was the participant's 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 the participant 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 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,

a. Were they 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, has the participant ever experienced Diabetic Ketoacidosis? ○ Yes ○ No ○ Unknown

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C. AUTOIMMUNE DISEASE HISTORY

1. Has the participant ever been diagnosed with an autoimmune disease(s) other than type 1 diabetes? ○ 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

D. REVIEW OF SYSTEMS

Site Number: Participant ID:
Date of Visit: Participant Letters:
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1. Record whether there are any abnormalities in the following systems review

	1) 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	
m. Other	○ Normal ○ Abnormal ○ Not Assessed	