Dear islet transplant recipient:

We hope you will be able to provide some information about your health since your last follow-up visit at our transplant center. We would be very grateful for your answers to this short questionnaire. This information is very important in the continuing search for a cure for Type 1 diabetes.

If you have an idea of what the answer to any question is, please provide your best recollection or estimate. If you have no idea what the answer to a question is, leave it blank. If you need any help completing the questionnaire, do not hesitate to call your transplant center coordinator.

1. Date of birth: _____ (mm/dd/yyyy)
2. Date of first islet transplant: _____ (mm/dd/yyyy)
3. Transplant center where you received your islets: __________________________________________
4. Have you used insulin in the past two weeks: ☐ Yes ☐ No
   If Yes, what is your average daily insulin use: _____ Total units per day
5. What is your most recent:
   a. HbA1c measurement: _____________ Month/Year: ______/______
   b. C-peptide measurement: _____________ Month/Year: _____/_______
      i. Did you fast before this measurement: ☐ Yes ☐ No
   c. Serum Creatinine measurement: _____________ Month/Year: ____/________
   d. Blood Glucose measurement: ____________ Month/Year: ____/________
      i. Did you fast before this measurement: ☐ Yes ☐ No
6. In the past year, how many times did you experience an episode of hypoglycemia that required the assistance of another person to recognize or help you treat the episode (you can answer 0 for none, or 1, 2, 3, 4, etc. If you can’t remember exactly how many, give your best estimate, for example, 5 or 10):______________
   i. How many of the above episodes involved a loss of consciousness and/or seizure:_______________ (0 for none, 1, 2, 3 etc. or your best estimate)
7. Have you received any other transplants since your last islet transplant at our center:
   a. Islet ☐ Yes ☐ No
      If yes,
      i. Currently functioning? ☐ Yes ☐ No
      ii. Month / year of transplant? ______
   b. Kidney ☐ Yes ☐ No
      If yes,
      i. Currently functioning? ☐ Yes ☐ No
      ii. Month / year of transplant? ______
c. **Pancreas** □ Yes □ No
   If yes,
   i. Currently functioning? □ Yes □ No
   ii. Month / year of transplant? ______

d. **Liver** □ Yes □ No
   If yes,
   i. Currently functioning? □ Yes □ No
   ii. Month / year of transplant? ______

e. **Heart** □ Yes □ No
   If yes,
   i. Currently functioning? □ Yes □ No
   ii. Month / year of transplant? ______

f. **Lung** □ Yes □ No
   If yes,
   i. Currently functioning? □ Yes □ No
   ii. Month / year of transplant? ______

8. **During the past 3 months**, have you had numbness, pain, tingling or loss of feeling in your hands or feet, other than from your hands or feet falling asleep: □ Yes □ No

9. **List all prescription medications that you are currently taking.** If you do not know the exact date when you started a medication, please write only the month/year or year. *If you need more room to write, please use the last page:*

   a. Medication name: _______________________________________________________
      i. Approximate start date: _____________________________________________
      ii. Dose (for example, 25 milligrams): ________________________________
      iii. Frequency (for example, twice a day): _____________________________
      iv. Route (for example, by mouth): ________________________________

   b. Medication name: _______________________________________________________
      i. Approximate start date: _____________________________________________
      ii. Dose (for example, 25 milligrams): ________________________________
      iii. Frequency (for example, twice a day): _____________________________
      iv. Route (for example, by mouth): ________________________________

   c. Medication name: _______________________________________________________
      i. Approximate start date: _____________________________________________
      ii. Dose (for example, 25 milligrams): ________________________________
      iii. Frequency (for example, twice a day): _____________________________
      iv. Route (for example, by mouth): ________________________________

   d. Medication name: _______________________________________________________
      i. Approximate start date: _____________________________________________
ii. Dose (for example, 25 milligrams): ____________________________________
iii. Frequency (for example, twice a day): _________________________________
iv. Route (for example, by mouth): _______________________________________

e. Medication name: ____________________________________________________
i. Approximate start date: ________________________________________________
ii. Dose (for example, 25 milligrams): ____________________________________
iii. Frequency (for example, twice a day): _________________________________
iv. Route (for example, by mouth): _______________________________________

f. Medication name: ____________________________________________________
i. Approximate start date: ________________________________________________
ii. Dose (for example, 25 milligrams): ____________________________________
iii. Frequency (for example, twice a day): _________________________________
iv. Route (for example, by mouth): _______________________________________

g. Medication name: ____________________________________________________
i. Approximate start date: ________________________________________________
ii. Dose (for example, 25 milligrams): ____________________________________
iii. Frequency (for example, twice a day): _________________________________
iv. Route (for example, by mouth): _______________________________________

h. Medication name: ____________________________________________________
i. Approximate start date: ________________________________________________
ii. Dose (for example, 25 milligrams): ____________________________________
iii. Frequency (for example, twice a day): _________________________________
iv. Route (for example, by mouth): _______________________________________

10. Have you had any medical problems, major illnesses, or experienced any adverse effects since the last follow-up: □ Yes □ No

If Yes, please describe each problem/event (if you need more room to write, please use the last page):

<table>
<thead>
<tr>
<th>EVENT</th>
<th>Have you experienced this event?</th>
<th>If Yes, when did this event start?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak or failing kidneys (do not include kidney stones, bladder infections, or incontinence):</td>
<td>□ No □ Yes-I was treated Yes-I was hospitalized</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em>__</td>
</tr>
<tr>
<td>EVENT</td>
<td>Have you experienced this event?</td>
<td>If Yes, when did this event start?</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Retinopathy – Diabetes affecting your eyes or vision</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>☐ No  ☐ Yes-I was treated</td>
<td>Month/Year: <em><strong><strong>/</strong></strong></em></td>
</tr>
<tr>
<td></td>
<td>☐ Yes-I was hospitalized</td>
<td></td>
</tr>
</tbody>
</table>

11. **Have you had any eye surgeries since your last visit to our center:**  ☐ Yes  ☐ No
   a. **If Yes,** indicate type of surgery: ________________________
   b. Month/Year: _____/_____  
   c. Which eye (Check one):  ☐ Right  ☐ Left  ☐ Both

12. **In general, would you say your health is**
   ☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor
Please provide any further information or any feedback regarding your participation in CITR:

Signature: ___________________________  Date: ___________________________

THANK YOU!!

Please send to your transplant center coordinator.