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. HbA_{1c} 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*):

EVENT	**Have you experienced this event?**	**If Yes, when did this event start?**
Weak or failing kidneys (do not include kidney stones, bladder infections, or incontinence):	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____

EVENT	Have you experienced this event?	If Yes, when did this event start?
Coronary heart disease	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Stroke	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Peripheral vascular disease	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Retinopathy – Diabetes affecting your eyes or vision	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Other:	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Other:	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Other:	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____
Other:	☐ No ☐ Yes-I was treated ☐ Yes-I was hospitalized	Month/Year: _____/_____

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.