



Last Name: _____ First Name: _____

Date of Birth: _____ Social Security Number: _____

Contact Information:

Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number: _____ Home Cell Work Other: (_____)

Additional Contact Number: _____ Home Cell Work Other: (_____)

Email address: _____ @ _____

Backup Contact information:

Who could we contact if we need to reach you but are unable to do so?

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number: _____ Home Cell Work Other: (_____)

Additional Contact Number: _____ Home Cell Work Other: (_____)

Physician Information:

Do you have a doctor who specializes in diabetes help you manage your care (endocrinologist, diabetologist or diabetes specialist)? Yes No

If yes, name of physician who helps manage your diabetes: _____

Telephone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

How often did you see this doctor in the last 12 months: _____



When was the last time you saw this doctor: _____

Do you have a doctor who is your primary care doctor? Yes No

If yes, name of primary care doctor: _____

Telephone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

How often do you see this doctor: _____

When was the last time you saw this doctor: _____

Insurance

Insurance Company Name _____ Name of Insured _____

Group Number _____ Plan Number _____

Personal Information

What is your height: _____

What is your weight (in pounds): _____

Females:

Are you pregnant Yes No

Are you Breastfeeding Yes No

Do you plan to become pregnant Yes No

How many pregnancies have you had:

Number of children and ages:

Males AND Females:

Are you willing to use effective contraception to prevent pregnancy for the duration of the study and 4 months after? Yes No

Do you smoke cigarettes Yes No

If yes, how many per day: _____



Do you consume alcohol Yes No

If yes, how many drinks per week: _____

Do you use medicinal marijuana Yes No

If yes, how often do you use it: _____

Do you currently use any illegal drugs or substances Yes No

If yes, name and frequency of use: _____

Diabetes History

Do you have Type I diabetes Yes No

Have you had diabetes for more than 5 years: Yes No

Month and year you were diagnosed with diabetes: _____

Have you been on insulin since you were first diagnosed with diabetes Yes No

Have you been on insulin for more than 5 years Yes No

Do you have difficulty controlling your blood sugars despite 3 or more insulin injections per day or using an insulin pump? Yes No

Do you experience low blood sugars (below 70mg/dL) that you are unaware of and require the assistance of another person Yes No

Have you required ambulance assistance/had to visit a hospital because of low blood sugar Yes No

If yes, in the past 12 months, please indicate the approximate dates, what you were doing at the time and what treatment you received

Do you own a glucagon injection kit to treat low blood sugar Yes No

If yes, in the past 12 months, have you used a glucagon injection to treat low blood sugar? Yes No

Have you experience any episodes of severe hypoglycemia in the past 12 months Yes No

Sever hypoglycemia is defined as an event with one of the following symptoms: memory loss; confusion; uncontrollable behavior; irrational behavior; unusual difficulty in awakening; suspected seizure; seizure; loss of consciousness; or visual symptoms, in which you are unable to treat yourself and was associated with a blood sugar level less than 54 mg/dL or prompt recovery after food/juice, IV glucose or glucagon administration.



Please indicate which of the following symptoms you experience when your blood sugar is low:

- Sweating
- Shaking
- Heart Palpitations
- Vision problems (impaired or double vision, eyes won't focus)
- Change in behavior (unable to sleep, irritable, feeling stressed out, nervous, wanting to sit down and do nothing)
- Confusion
- Seizure
- Other (light-headed, dizzy, weakness, tiredness, sleepy, difficulty walking or speaking, slow response, delayed motor skills, loss of balance)
- Other (please specify):

None

In general please rank on a scale of 1 to 5 about how stable you feel your diabetes is:

- 1 Very Stable 2 Stable 3 somewhat stable 4 Unstable 5 Very Unstable

Insulin:

What type of insulin do you use (check all that apply):

- Aspart/Novolog
- Lispro/Humalog
- Glulisine/Aprida
- Regular /Novolin R/Humulin R
- NPH/Novolin N/Humulin N
- Insulin Mix (i.e. 70/30, 70/25, etc)
- Detemir/Levemir
- Glargine/Lantus
- Other: _____

How do you give yourself insulin?

- I use an insulin pump
- I use an insulin pen (i.e. solostar, flex pen, etc)
- I use a vial and syringe

If you are on a pump, please provide your 24 hour settings:



Islet Cell Transplant Program Intake Questionnaire

What is your insulin to carbohydrate ratio or what is the amount of insulin you take with meals: _____

What is your insulin to blood glucose correction: _____

What is your TOTAL DAILY Insulin use?

how much TOTAL insulin do you inject each day(midnight-midnight), please collect this for a total of 7 days:

Day	How Much Insulin you used for the whole day (midnight-midnight)
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Please complete ALL of the time points in the table below in order to determine an average amount of your blood glucose highs and lows, please check your blood sugar level 7 times a day, before and after meals and before bedtime for two days in a row. Please do not miss any recordings:

DATE	BEFORE BREAKFAST	AFTER BREAKFAST	BEFORE LUNCH	AFTER LUNCH	BEFORE DINNER	AFTER DINNER	BEFORE BEDTIME
GLUCOSE LEVEL							
NUMBER OF CARBS EATEN							
INSULIN DOSE							
INSULIN TYPE							

DATE	BEFORE BREAKFAST	AFTER BREAKFAST	BEFORE LUNCH	AFTER LUNCH	BEFORE DINNER	AFTER DINNER	BEFORE BEDTIME
GLUCOSE LEVEL							



NUMBER OF CARBS EATEN							
INSULIN DOSE							
INSULIN TYPE							

Diabetes Survey

Clarke Hypoglycemic Index

- Check the category that best describes you (only one):
 - I ALWAYS have symptoms when my blood sugar is low
 - I SOMETIMES have symptoms when my blood sugar is low
 - I NO LONGER have symptoms when my blood sugar is low
- Have you lost some of the symptoms that used to occur when your blood sugar was low
 - Yes No
- In the past 6 months, how often have you had moderate hypoglycemia episodes (when you might feel confused, disoriented, lethargic and were unable to treat yourself)
 - Never once or twice every other month once a month more than once a month
- In the past year, how often have you had sever hypoglycemia episodes (see pg 3 for definition of severe hypoglycemia)
 - Never 1 time 2 times 3 times 4 times 5 times 6 times 7 times
 - 8 times 9 times 10 times 11 times 12 or more times
- How often in the last month have you had readings <70 mg/dL WITH symptoms?
 - Never 1 to 3 times 1 time a week 2 to 3 times a week 4 to 5 times a week almost daily
- How often in the last month have you had readings <70 mg/dL WITHOUT symptoms?
 - Never 1 to 3 times 1 time a week 2 to 3 times a week 4 to 5 times a week almost daily
- How low does your blood sugar need to go before you feel symptoms?
 - 60-69 mg/dL 50-59 mg/dL 40-49 mg/dL <40 mg/dL
- To what extent can you tell by your symptoms that your blood sugar is low?
 - Never Rarely Sometimes Often Always

Internal use:
Clarke Hypoglycemic Index Score: _____



- Seizure (other than due to low blood sugar) Yes No
- Epilepsy Yes No
- Brain tumor Yes No
- Cognitive impairment Yes No
- Multiple sclerosis Yes No

Have you ever received psychiatric treatment or been diagnosed with a psychiatric or mental illness Yes No

Respiratory

Have you ever been diagnosed with and/or treated for

- Asthma Yes No
- Emphysema Yes No
- Pulmonary edema Yes No

Abdomen and Gastrointestinal (GI)

Do you have trouble digesting food Yes No

Do you regularly have severe diarrhea or nausea/vomiting Yes No

Have you ever been diagnosed with gastroparesis Yes No

Have you ever had abdominal surgery Yes No

If yes, describe _____

Do you have a colostomy/ileostomy Yes No

Have you ever had any abdominal hernia(s) (inguinal, incisional, peri-umbilica) Yes No

Do you have any other GI problems Yes No

If yes, please specify _____

Do you regularly follow with a gastrointestinal (GI) doctor Yes No

If yes, Name of your doctor: _____

Phone Number: _____ Fax number: _____

Kidneys

Have you ever been diagnosed with and/or treated for

- Kidney disease Yes No
- ANY kidney dysfunction Yes No

Have you had your urine checked for protein in the last 12 months Yes No

If yes, have you ever been told you have protein in your urine Yes No

Do you regularly follow with a kidney doctor (Nephrologist) Yes No

If yes, Name of your kidney doctor: _____

Phone Number: _____ Fax number: _____

Heart and Vascular

Have you ever been diagnosed with and/or treated for



- High blood pressure Yes No
- High cholesterol Yes No
- A bleeding problem Yes No
- A clotting problem Yes No
- Congestive Heart Failure Yes No
- A Stroke Yes No
- Poor wound healing Yes No
- Peripheral Vascular Disease Yes No
- Heart attack Yes No

Have you ever been diagnosed with a heart problem not listed above Yes No

If yes, please specify: _____

Do you regularly follow with a heart or vascular doctor Yes No

If yes, Name of your heart or vascular doctor: _____

Phone Number: _____ Fax number: _____

Diabetic neuropathy

Do you have any loss of sensation, numbness, tingling in your hands or feet? Yes No

If yes, please indicate the degree of sensory loss: mild moderate severe

Have you ever had a sever foot infection Yes No

Have you ever had an amputation Yes No

If yes, when and what limb _____

How often do you check your feet for ulcerations or infections?

Never less than 1 time a month 1-2 times a month 1-2 times a week Daily

Other

Have you ever had a blood transfusion Yes No

Have you ever had an organ transplant Yes No

If yes, what organ and when _____

Have you ever been diagnosed and/or treated for any cancer Yes No

If yes, what type and when: _____

Have you ever been diagnosed with and/or treated for:

- Hepatitis B Yes No
- Hepatitis C Yes No
- HIV Yes No
- Tuberculosis (TB) Yes No
- Lupus Yes No
- Sickle Cell Anemia Yes No
- Arthritis Yes No
- Grave's disease Yes No

In the last 12 months, Have you ever been diagnosed with and/or treated for



Are you willing and able to travel to The University of Chicago Medicine for appointments, treatment and follow up Yes No

Additional Information

*The following information will NOT be used to determine participation in the study

Gender: Male Female

Citizenship: U.S. Citizen Resident Alien Non-Resident Alien

Ethnicity: Hispanic Non-Hispanic

Race: White Black/African American American Indian/Alaskan Native Asian
 Arab/Middle Eastern American Hawaiian/Pacific Islander Other

Highest Education Level: None Grade School (0-8) High School (9-12)
 Attended College/Trade School Associate Degree Bachelors Degree
 Masters Degree Doctoral Degree

Employment Status: Not Working due to Disability Not Working by Choice
 Unable to find work Not working- other Working Part Time due to Disability
 Working Part Time by Choice Working Part Time- other Retired
 Working Full Time

What type of work do you do: _____