THE UNIVERSITY OF CHICAGO MEDICINE

Islet Cell Transplant Program Intake Questionnaire

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:
_____

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

1. 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

2. Have you lost some of the symptoms that used to occur when your blood sugar was low
   ☐ Yes ☐ No

3. 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
4. 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
5. 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
6. 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
7. 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

8. 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: _____

Are you allergic to any medications: ☐ Yes ☐ No

If yes, please list medication and reaction you have: _____

Are you allergic to polypropylene, PTFE or RTV Silicone ☐ Yes ☐ No

Are you allergic to anything else ☐ Yes ☐ No

If yes, please list allergen and reaction you have: _____

Please list ALL medications that you take (include prescription medications along with over the counter medications such as vitamins and supplements)

Medication name	Dose	How often	How long have you been on it	Why do you take it

Eyes

Do you get your eyes checked at least once a year ☐ Yes ☐ No

When was your last eye exam: _____

Name of your eye doctor: _____

Phone Number: _____ Fax number: _____

Have you ever been diagnosed with diabetic retinopathy ☐ Yes ☐ No

Do you have any significant vision loss from your diabetes ☐ Yes ☐ No

Have you ever had laser treatment ☐ Yes ☐ No

Have you ever had eye surgery ☐ Yes ☐ No

Neurological

Have you ever been diagnosed with and/or treated for

- 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

- Invasive aspergillus ☐ Yes ☐ No
- Histoplasmosis ☐ Yes ☐ No
- Coccidiodomycosis ☐ Yes ☐ No

Surgery

Do you have any issues that would prevent you from having general anesthesia ☐ Yes ☐ No

If yes, please explain _____

Have you ever had surgery ☐ Yes ☐ No

If yes, please provide information below for ALL surgeries you have any

Type of surgery	date	reason

Do you have any other medical issues, diagnoses, etc that you feel it is important for the transplant team to be aware of

_____

_____

_____

What do you expect to change after an islet cell transplant

_____

_____

_____

_____

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: _____