UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

This form is for people who have diabetes. If you do not have diabetes, please return this form to the receptionist.

There's more to diabetes than just type 1 and type 2

You may qualify for a study that could tell if you have a special type of diabetes.

What is this study about?

We want to improve access to diagnosis and treatment of a type of diabetes called ***monogenic diabetes***. Many people with monogenic diabetes do not know they have it.

Why is this important?

Knowing you have monogenic diabetes could:

- Improve your sugar control
- Improve your quality of life
- Help find family members who have monogenic diabetes
- Help others with diabetes

Please complete the form if you are willing to be contacted for the study. Filling out the form is your choice. Deciding not to fill it out will not affect your relationship with your doctor at University of Maryland or the VA Maryland Health Care System. You will be contacted by the study team if your answers indicate you qualify for the study.

If you qualify, being in the study involves 1 – 2 visits lasting up to 1 hour each. Payment for your time will be provided. **You may learn new information about your diabetes that may improve your health.**

If you have completed this before, please do not fill it out again.

If you have any questions, call Devon Nwaba at 410-706-6140. Thank you for your time!

Patient Name: _____ Date: _____

Phone No. _____ Email address: _____

Patient's Date of Birth: _____ Form completed by: ☐Patient ☐Other_____

Patient is: ☐ Male ☐ Female

Patient's Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Patient's Race (check all that apply):
☐ African-American or Black
☐ Caucasian or White
☐ Asian
☐ Pacific Islander or Native Hawaiian
☐ American Indian or Alaskan Native

Have you been diagnosed with the following? (check all that apply)

☐ Type 1 diabetes
☐ Type 2 diabetes
☐ Gestational diabetes
☐ Pre-diabetes or high blood sugar

1. Were you diagnosed with diabetes or high blood sugar before 1 year of age?
   ☐ Yes ☐ No

2. Were you diagnosed with diabetes or high blood sugar at age 30 or younger?
   ☐ Yes ☐ No

   How old were you when you were diagnosed?_____

3. Were you extremely overweight when you were diagnosed?
   ☐ Yes ☐ No

4. As a child, did/do you have hearing or vision problems, intellectual disability (for example, learning disabilities, mental retardation, autism), birth defect(s) or kidney disease?

   ☐ Yes ☐ No If yes, describe: _____

5. Do you have type 1 diabetes (if unsure, were you on insulin at diagnosis and have been ever since)?
   ☐ Yes ☐ No

6. Do you have a parent or a child with type 1 diabetes?
   ☐ Yes ☐ No

7. Do you have 2 or more people related to you by blood with diabetes?*
   ☐ Yes ☐ No *** If yes, please complete Family History Questionnaire (next page).**

Staff Use Only: **PDMP IQ Version 6**

Screening ID # _____

☐ Physician referral ☐ Clinic screen (specify clinic) _____
☐ Self referral ☐ Target screen, e.g. data pull (specify criteria)

Family History Questionnaire

Patient Name: _____ Date: _____

Please fill-out for all people related to you by blood with diabetes:

Relationship to You **(For example, mother, sister, son, grandfather, aunt)**	**Approximate Age of Diabetes Diagnosis**	**Type of Diabetes** **(Type 1, 2, not sure)**