

**CADDRE**  
**PRENATAL CHART**  
**ABSTRACTION FORM**

**(11/14/2005)**

STUDY ID Number:

STUDY ID Number:

<b>A. IDENTIFYING INFORMATION</b>				<input type="checkbox"/> No Info
1. Mother's name (Last, First, Middle)		2. Study ID#		
3. Maiden Name		4. AKA		
5. Mother's Medical Record Number		6. SSN	7. Mother's DOB	
8. Street Address		9. City	10. State	11. Zip Code
12. Provider/Clinic Name				
13. Clinic Street Address		14. City	15. State	16. Zip Code
17. Provider/Clinic Name				
18. Clinic Street Address		19. City	20. State	21. Zip Code
22. Provider/Clinic Name				
23. Clinic Street Address		24. City	25. State	26. Zip Code
27. Delivery Hospital				
28. Delivery Hospital Address		29. City	30. State	31. Zip code
32. Date Abstracted ____/____/____		33. Abstractor		
34. Start Time :		35. Stop Time :		
36. Start Time :		37. Stop Time :		
38. Start Time :		39. Stop Time :		
40. Start Time :		41. Stop Time :		
<b>Comments:</b>				

STUDY ID Number:

**MATERNAL ADDRESS HISTORY**

9. Date __ / __ / ____	10. Mother's Street Address		
11. City		12. State	13. Zip Code
14. Date __ / __ / ____	15. Mother's Street Address		
16. City		17. State	18. Zip Code
19. Date __ / __ / ____	20. Mother's Street Address		
21. City		22. State	23. Zip Code
24. Date __ / __ / ____	25. Mother's Street Address		
26. City		27. State	28. Zip Code
29. Date __ / __ / ____	30. Mother's Street Address		
31. City		32. State	33. Zip Code
34. Date __ / __ / ____	35. Mother's Street Address		
36. City		37. State	38. Zip Code
39. Date __ / __ / ____	40. Mother's Street Address		
41. City		42. State	43. Zip Code

**COMMENTS:**

STUDY ID Number:

**B. MENSTRUAL HISTORY, CONCEPTION, INFERTILITY, PRENATAL CARE**  No Info

1. Date of first PNV ____/____/____ 99. <input type="checkbox"/> unknown	2. Date of last PNV ____/____/____ 99. <input type="checkbox"/> unknown	3. Total # Visits 99. <input type="checkbox"/> unknown
4. LMP Date ____/____/____ 99. <input type="checkbox"/> unknown	5. LMP date certain? 1. • Yes 2. • No 9. • Unknown	6. EDC-LMP 99. <input type="checkbox"/> unknown
7. EDC-US 99. <input type="checkbox"/> unknown	8. Number of months current pregnancy attempted _____ months 77. • Unplanned 99. <input type="checkbox"/> unknown	
9. Contraceptives in use at time of conception? 1. • None/rhythm 2. • Barrier/chemical 3. • Hormonal 4. • IUD 9. • Unknown		10. Date contraceptives stopped: ____/____/____ 99. <input type="checkbox"/> unknown
11. Conception 1. • Spontaneous 2. • Assisted _____ 3. • Delayed 9. • Unknown	12. Menstrual History Age of onset _____ 99. <input type="checkbox"/> unknown	13. Menstrual cycles 1. • Regular 2. • Irregular 9. • Unknown
14. Intercycle Interval _____ days 99. <input type="checkbox"/> unknown	15. Duration _____ days 99. <input type="checkbox"/> unknown	

16. Infertility Diagnosis	Index Preg	Past History/Not including index pregnancy	17. Infertility Treatment (INDEX pregnancy) check all that apply:
Tubal Factor	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• IUI (intrauterine insemination)</li> <li>• CI or ICI (cervical insemination)</li> <li>• IVF (in vitro fertilization)</li> <li>• GIFT(gamete intrafallopian transfer)</li> <li>• ZIFT (zygote intrafallopian transfer)</li> <li>• TET (tubal embryo transfer)</li> <li>• Egg Donor</li> <li>• Egg Recipient</li> <li>• Gestational surrogate</li> <li>• Frozen embryo transfer (FET/CET)</li> <li>• ICSI (intracytoplasmic sperm injection)</li> <li>• Open fallopian tubes</li> <li>• Rejoin fallopian tubes</li> <li>• Treatment of uterine fibroids</li> <li>• Removal of endometriosis</li> <li>• Infertility treatment not specified/unknown</li> </ul>
Ovulatory Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	
Diminished ovarian reserve	<input type="checkbox"/>	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine factor	<input type="checkbox"/>	<input type="checkbox"/>	
Male Factor	<input type="checkbox"/>	<input type="checkbox"/>	
Unexplained cause	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	
Unknown/No Info	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/> <b>INFERTILITY (past or index pregnancy) NO INFO</b>

<b>18. Infertility Medications</b> M=Mother F=Father	Medication	F	M	Medication	F	M	Medication	M	F
	Baby aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Fertinex	<input type="checkbox"/>	<input type="checkbox"/>	Pergonal	<input type="checkbox"/>	<input type="checkbox"/>
	Bromocriptin	<input type="checkbox"/>	<input type="checkbox"/>	Follistim	<input type="checkbox"/>	<input type="checkbox"/>	Pregnyl	<input type="checkbox"/>	<input type="checkbox"/>
	Clomid	<input type="checkbox"/>	<input type="checkbox"/>	Gonal-F	<input type="checkbox"/>	<input type="checkbox"/>	Profasi	<input type="checkbox"/>	<input type="checkbox"/>
	Clomiphene citrate	<input type="checkbox"/>	<input type="checkbox"/>	Heparin	<input type="checkbox"/>	<input type="checkbox"/>	Prometrium	<input type="checkbox"/>	<input type="checkbox"/>
	Crinone	<input type="checkbox"/>	<input type="checkbox"/>	Lupron	<input type="checkbox"/>	<input type="checkbox"/>	Provera	<input type="checkbox"/>	<input type="checkbox"/>
	Danazol	<input type="checkbox"/>	<input type="checkbox"/>	Metrodin	<input type="checkbox"/>	<input type="checkbox"/>	Repronex	<input type="checkbox"/>	<input type="checkbox"/>
	Danocrine	<input type="checkbox"/>	<input type="checkbox"/>	Lutrepulse	<input type="checkbox"/>	<input type="checkbox"/>	Serophene	<input type="checkbox"/>	<input type="checkbox"/>
	Dostinex	<input type="checkbox"/>	<input type="checkbox"/>	Novarel	<input type="checkbox"/>	<input type="checkbox"/>	Steroid tx (Specify)	<input type="checkbox"/>	<input type="checkbox"/>
	Factrel	<input type="checkbox"/>	<input type="checkbox"/>	Parlodel	<input type="checkbox"/>	<input type="checkbox"/>	Synarel	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:** \_\_\_\_\_

STUDY ID Number:

<b>C. PREGNANCY HISTORY</b>						<input type="checkbox"/> <b>No Info</b>
1. Gravida	2. Para	3. Stillbirths/SAB	4. TAB	5. Preterm (<37 wks)	6. Term (≥37 wks)	

**\*\*Use the following codes to complete the table below\*\***

Sex	Plurality	Zygoty	Outcome
1. Male 2. Female 3. Ambiguous 9. Unknown	11. Singleton 20. Twin NOS * 21. Twin A 22. Twin B  *NOS = not otherwise stated	1. monozygotic (mz) 2. Dizygotic (dz) 9. Unknown  <b>Trimesters</b> 1) weeks 1-12 2) weeks 13-26 3) weeks 27-40 +	1. SAB (<20 wks) 2. TAB 3. Live Birth 4. Stillbirth ≤ 20 weeks 5. Neonatal death (0-28 days) 6. Postneonatal death (28 days -1 year) 7. Death (>1 year) 8. Death (NOS) * If death occurred code and write reason in outcome box 9. Ectopic pregnancy 10. Molar pregnancy 88 Other specify 99. Unknown

**Prenatal & Delivery Problems /Complications**

1. No complications noted 2. Abruptio placentae 3. Birth defect 4. Cephalopelvic disproportion 5. Cesarean section delivery 6. Chorioamnionitis 7. Deep vein thrombosis 8. Eclampsia 9. Fetal reduction 10. Gestational Diabetes 11. HELLP 12. Hyperemesis 13. Intrauterine growth restriction/retardation (IUGR)	14. Macrosomia 15. Placenta previa 16. Postpartum depression 17. Postpartum hemorrhage 18. Pregnancy induced hypertension/preeclampsia/gestational hypertension 19. Premature rupture of membranes (PROM) 20. Preterm labor 21. Pulmonary edema 22. Pulmonary embolus (PE) 23. Uterine rupture 24. Vaginal bleeding 88. Other: specify 99. Unknown/Not Documented
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Preg No.	Baby No.	Delivery Mo.	Delivery Yr.	Wt			GA (wks)	Sex	Plurality	Zygoty	Outcome	Prenatal & Delivery Problems / Complications
				gm	lb	oz						

STUDY ID Number:

Comments:

**D. MATERNAL BASELINE MEASUREMENTS (WEIGHT, HEIGHT, AND BLOOD PRESSURE)**

No Info

	Date	GA	Measurement			Date	GA	Measurement		
1. Pre-pregnancy weight	____/____/____ 99. <input type="checkbox"/> unknown		lb	kg	5. Pre-pregnancy maternal height			ft	in	cms
			____.____	____.____					99. <input type="checkbox"/> unknown	
			99. <input type="checkbox"/> unknown							
2. First PNV weight	____/____/____ 99. <input type="checkbox"/> unknown		lb	kg	6. First PNV BP	____/____/____ 99. <input type="checkbox"/> unknown		/ sys/dias		
		99. <input type="checkbox"/> unk	____.____	____.____				99. <input type="checkbox"/> unk	99. <input type="checkbox"/> unknown	
			99. <input type="checkbox"/> unknown							
3. Last PNV weight	____/____/____ 99. <input type="checkbox"/> unknown		lb	kg	7. Second PNV BP	____/____/____ 99. <input type="checkbox"/> unknown		/ sys/dias		
		99. <input type="checkbox"/> unk	____.____	____.____				99. <input type="checkbox"/> unk	99. <input type="checkbox"/> unknown	
			99. <input type="checkbox"/> unknown							
4. Admission weight	____/____/____ 99. <input type="checkbox"/> unknown		lb	kg	8. . $\approx$ 20 weeks PNV BP	____/____/____ 99. <input type="checkbox"/> unknown		/ sys/dias		
		99. <input type="checkbox"/> unk	____.____	____.____				99. <input type="checkbox"/> unk	99. <input type="checkbox"/> unknown	
			99. <input type="checkbox"/> unknown							

Comments:

STUDY ID Number:

<b>E. BLOOD TYPE AND SCREENINGS</b>						<input type="checkbox"/> No Info
<b>1. Blood type and Rh</b>  + / - 99. <input type="checkbox"/> unknown	<b>2. Antibody screen</b> 1. • Neg 2. • Pos _____ 99. <input type="checkbox"/> unknown	<b>3. RPR/VDRL</b> 1. • NR 2. • React 99. <input type="checkbox"/> unknown	<b>4. HbsAG</b> 1. • Neg 2. • Pos 99. <input type="checkbox"/> unknown	<b>5. Rubella Titer</b> 1. • Im 2. • Non-im 99. <input type="checkbox"/> unknown	<b>6. HIV • Done</b> 1. • Neg 2. • Pos 99. <input type="checkbox"/> unknown	
<b>7. Hgb electrophoresis</b> <span style="float: right;">Date</span>  1. • Neg   ____/____/_____ 2. • Pos _____ 99. <input type="checkbox"/> unknown			<b>8. Triple Marker</b> <span style="float: right;">Date</span>  1. • NL   ____/____/_____ 2. • ABNL _____ 99. <input type="checkbox"/> unknown  <u>Numeric results:</u> AFP: _____ <input type="checkbox"/> Declined Unconjugated estriol: _____ Hcg: _____			
<b>9. MSAFP</b> <span style="float: right;">Date</span>  1. • NL   ____/____/_____ 2. • ABNL _____ 99. <input type="checkbox"/> unknown MS-AFP Accession number:			<b>10. Progesterone level</b> <span style="float: right;">Date</span>  1. • NL   ____/____/_____ 2. • ABNL _____ 99. <input type="checkbox"/> unknown			
<b>11. Chorionic Villi Sampling</b> <span style="float: right;">Date</span>  1. • NL   ____/____/_____ 2. • ABNL _____ 99. <input type="checkbox"/> unknown			<b>12. Amniocentesis</b> <span style="float: right;">Date</span>  karyotype _____   ____/____/_____  99. <input type="checkbox"/> unknown			
<b>13. Amnio gram stain</b> <span style="float: right;">Date</span>  1. • Neg   ____/____/_____ 2. • Pos _____ 99. <input type="checkbox"/> unknown		<b>14. Amnio lung maturity</b> <span style="float: right;">Date</span>  LS _____ PG _____ FSI _____   ____/____/_____  99. <input type="checkbox"/> unknown				
<b>15. C-reactive protein lab values</b>						
First PNV value		_____ <input type="checkbox"/> unknown	date ____/____/_____		<input type="checkbox"/> unknown	
Delivery admission value		_____ <input type="checkbox"/> unknown	date ____/____/_____		<input type="checkbox"/> unknown	
Closest to delivery value		_____ <input type="checkbox"/> unknown	date ____/____/_____		<input type="checkbox"/> unknown	
First postpartum value		_____ <input type="checkbox"/> unknown	date ____/____/_____		<input type="checkbox"/> unknown	
<b>Comments:</b>  <div style="border: 1px solid black; height: 100px; width: 100%;"></div>						



<b>F. ULTRASOUND REPORTS</b>					<input type="checkbox"/> No Info
1. Date of scan  ____/____/____  99. • unknown	#fetuses	EGA-dates	EGA-US	Reason (check all that apply)  1. • <b>Confirm dates</b> 2. • <b>Fetal growth</b> 3. • <b>Placenta</b> 4. • <b>BPP</b> 5. • <b>Decreased fetal movement</b> 6. • <b>Amniotic fluid volume</b> 7. • <b>Malformation</b> 8. • <b>Other: (Specify)</b>  _____ 99. • unknown	Results:  1. • Normal 2. • Abnormal  _____ _____  99. <input type="checkbox"/> unknown
Comments					
2. Date of scan  ____/____/____  99. • unknown	#fetuses	EGA-dates	EGA-US	Reason (check all that apply)  1. • <b>Confirm dates</b> 2. • <b>Fetal growth</b> 3. • <b>Placenta</b> 4. • <b>BPP</b> 5. • <b>Decreased fetal movement</b> 6. • <b>Amniotic fluid volume</b> 7. • <b>Malformation</b> 8. • <b>Other: (Specify)</b>  _____ 99. • unknown	Results:  1. • Normal 2. • Abnormal  _____ _____  99. <input type="checkbox"/> unknown
Comments					
3. Date of scan  ____/____/____  99. • unknown	#fetuses	EGA-dates	EGA-US	Reason (check all that apply)  1. • <b>Confirm dates</b> 2. • <b>Fetal growth</b> 3. • <b>Placenta</b> 4. • <b>BPP</b> 5. • <b>Decreased fetal movement</b> 6. • <b>Amniotic fluid volume</b> 7. • <b>Malformation</b> 8. • <b>Other: (Specify)</b>  _____ 99. • unknown	Results:  1. • Normal 2. • Abnormal  _____ _____  99. <input type="checkbox"/> unknown
Comments					

STUDY ID Number:

<b>F. ULTRASOUND REPORTS (cont'd)</b>					
4. Date of scan  ___/___/___ 99. • unknown	#fetuses	EGA-dates	EGA-US	Reason (check all that apply)  1. • <b>Confirm dates</b> 2. • <b>Fetal growth</b> 3. • <b>Placenta</b> 4. • <b>BPP</b> 5. • <b>Decreased fetal movement</b> 6. • <b>Amniotic fluid volume</b> 7. • <b>Malformation</b> 8. • <b>Other: (Specify)</b>  _____ 99. • unknown	Results:  1. • Normal 2. • Abnormal  _____ _____  99. <input type="checkbox"/> unknown
Comments					
5. Date of scan  ___/___/___ 99. • unknown	#fetuses	EGA-dates	EGA-US	Reason (check all that apply)  1. • <b>Confirm dates</b> 2. • <b>Fetal growth</b> 3. • <b>Placenta</b> 4. • <b>BPP</b> 5. • <b>Decreased fetal movement</b> 6. • <b>Amniotic fluid volume</b> 7. • <b>Malformation</b> 8. • <b>Other: (Specify)</b>  _____ 99. • unknown	Results:  1. • Normal 2. • Abnormal  _____ _____  99. <input type="checkbox"/> unknown
Comments					
6. Date of scan  ___/___/___ 99. • unknown	#fetuses	EGA-dates	EGA-US	Reason (check all that apply)  1. • <b>Confirm dates</b> 2. • <b>Fetal growth</b> 3. • <b>Placenta</b> 4. • <b>BPP</b> 5. • <b>Decreased fetal movement</b> 6. • <b>Amniotic fluid volume</b> 7. • <b>Malformation</b> 8. • <b>Other: (Specify)</b>  _____ 99. • unknown	Results:  1. • Normal 2. • Abnormal  _____ _____  99. <input type="checkbox"/> unknown
Comments					
<b>Comments:</b>					

<b>G. SUBSTANCE ABUSE</b>					<input type="checkbox"/> No Info
	3 mos prior to conception through conception	Trimester 1 Weeks 1-12	Trimester 2 13-26	Trimester 3 27-40 +	Date stopped
<b>a. Drugs/Subs.</b>					
a1. Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	____/____/____  <b>99. • unknown</b>
a2. Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	____/____/____  <b>99. • unknown</b>
a3. Ecstasy, speed, methamphetamines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	____/____/____  <b>99. • unknown</b>
a3. Other(specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated	____/____/____  <b>99. • unknown</b>
<b>b. Tobacco</b>					
	____cigs/day  ____packs/day  ____packs/wk  <input type="checkbox"/> No <input type="checkbox"/> Unknown	____cigs/day  ____packs/day  ____packs/wk  <input type="checkbox"/> No <input type="checkbox"/> Unknown	____cigs/day  ____packs/day  ____packs/wk  <input type="checkbox"/> No <input type="checkbox"/> Unknown	____cigs/day  ____packs/day  ____packs/wk  <input type="checkbox"/> No <input type="checkbox"/> Unknown	____/____/____  <b>99. • unknown</b>
<b>c. Alcohol</b>					
	____drinks/day    ____  ____drinks/week  or  • heavy • moderate/ social • occasional • rarely/ minimal <input type="checkbox"/> No <input type="checkbox"/> Unknown	____drinks/day  ____drinks/week  or  • heavy • moderate/ social • occasional • rarely/ minimal <input type="checkbox"/> No <input type="checkbox"/> Unknown	____drinks/day    ____  ____drinks/week  or  • heavy • moderate/ social • occasional • rarely/ minimal <input type="checkbox"/> No <input type="checkbox"/> Unknown	____drinks/day  ____drinks/week  or  • heavy • moderate/ social • occasional • rarely/ minimal <input type="checkbox"/> No <input type="checkbox"/> Unknown	____/____/____  <b>99. • unknown</b>
<b>Comments:</b>					

STUDY ID Number:

<b>H. MATERNAL INFECTIONS ANYTIME DURING CURRENT PREGNANCY</b> <span style="float: right;"><input type="checkbox"/> No Info</span>								
Dx: Use codes from Infection List (Appendix )								
If cultures were performed, note in Section I.								
If "yes" is indicated for medications, please fill out Section R.								
a. Dx	Date diagnosed ____/____/_____ 9. • unknown	G A	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • unknown	Duration ____ days 9. • unk	Highest temp °C _____ °F _____ 1. • No temp 999. • unk	Cultures 1. • Yes 2. • No 9. • Unknown	Medication given 1. • Yes 2. • No 9. • Unknown
b. Dx	Date diagnosed ____/____/_____ 9. • unknown	G A	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • unknown	Duration ____ days 9. • unk	Highest temp °C _____ °F _____ 1. • No temp 999. • unk	Cultures 1. • Yes 2. • No 9. • Unknown	Medication given 1. • Yes 2. • No 9. • Unknown
c. Dx	Date diagnosed ____/____/_____ 9. • unknown	G A	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • unknown	Duration ____ days 9. • unk	Highest temp °C _____ °F _____ 1. • No temp 999. • unk	Cultures 1. • Yes 2. • No 9. • Unknown	Medication given 1. • Yes 2. • No 9. • Unknown
d. Dx	Date diagnosed ____/____/_____ 9. • unknown	G A	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • unknown	Duration ____ days 9. • unk	Highest temp °C _____ °F _____ 1. • No temp 999. • unk	Cultures 1. • Yes 2. • No 9. • Unknown	Medication given 1. • Yes 2. • No 9. • Unknown
e. Dx	Date diagnosed ____/____/_____ 9. • unknown	G A	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • unknown	Duration ____ days 9. • unk	Highest temp °C _____ °F _____ 1. • No temp 999. • unk	Cultures 1. • Yes 2. • No 9. • Unknown	Medication given 1. • Yes 2. • No 9. • Unknown
f. Dx	Date diagnosed ____/____/_____ 9. • unknown	G A	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • unknown	Duration ____ days 9. • unk	Highest temp °C _____ °F _____ 1. • No temp 999. • unk	Cultures 1. • Yes 2. • No 9. • Unknown	Medication given 1. • Yes 2. • No 9. • Unknown
<b>Fever &gt;37.7°C or 100°F</b> <span style="float: right;"><input type="checkbox"/> No Info</span>								
	<b>5 highest fevers</b>	<b>Date</b>			<b>Time</b>			
1.	°C _____ °F _____ 99. • unknown	____/____/_____			99. • unknown			
2.	°C _____ °F _____ 99. • unknown	____/____/_____			99. • unknown			

STUDY ID Number:

**Fever >37.7°C or 100°F(cont'd)**

3.	°C _____ °F _____ 99. • unknown	___ / ___ / _____	99. • unknown
4.	°C _____ °F _____ 99. • unknown	___ / ___ / _____	99. • unknown
5.	°C _____ °F _____ 99. • unknown	___ / ___ / _____	99. • unknown
<b>Comments:</b>			

STUDY ID Number:

**I. CULTURES ANYTIME DURING CURRENT PREGNANCY (RECORD ALL CULTURES OBTAINED)- Indicate the number of the event from section H. If the culture does not correspond to an event in section H, then enter '0'.  No Info**

**Source: 1= amniotic fluid, 2= placenta, 3= cervix, 4= vagina, 5=urine, 6=blood, 7= sputum, 8= stool, 88= other, (specify), 99= unknown**

Refer	Date cultured	Source	Results	Description (organisms, etc)
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	
	___/___/___ 99. • unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specified 99. • unknown	

**Comments:**

STUDY ID Number:

<b>J. OTHER ABNORMAL REPORTS</b>				<input type="checkbox"/> No Info
Refer	Test Date	Test Name/Description	Results	Comments
	_ _ / _ _ / _ _ _ _		1. • Normal 2. • Abnormal: _____ 9. • unknown	
	_ _ / _ _ / _ _ _ _		1. • Normal 2. • Abnormal: _____ 9. • unknown	
	_ _ / _ _ / _ _ _ _		1. • Normal 2. • Abnormal: _____ 9. • unknown	

**Comments**

<b>K. INJECTIONS/VACCINATIONS DURING CURRENT PREGNANCY</b>				<input type="checkbox"/> No Info
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Injection/vaccination					
	Date	Dose	Manufacturer	Product Name	Lot #
Rhogam (or other RH(D)) immunoglobulin	First _ _ / _ _ / _ _ _ _ 99. • Unknown  Second _ _ / _ _ / _ _ _ _ 99. • Unknown	First _____ 99. • No Info  Second _____ 99. • Unknown	First _____ 99. • No Info  Second _____ 99. • Unknown	First _____ 99. • No Info  Second _____ 99. • Unknown	
Influenza vaccine	Date _ _ / _ _ / _ _ _ _ 99. • Unknown		Manufacturer 99. • Unknown		Lot # 99. • Unknown
Other (specify) _____	Date _ _ / _ _ / _ _ _ _ 99. • Unknown		Manufacturer 99. • Unknown		Lot # 99. • Unknown

**Comments:**

STUDY ID Number:

<b>L.VAGINAL BLEEDING ANYTIME DURING CURRENT PREGNANCY</b> <span style="float: right;"><input type="checkbox"/> No Info</span>							
Dx: 1=Placenta previa, 2= Placental abruption, 3= Trauma, 4= Effaced/dilated, 5= Uterine rupture, 6= Implantation bleeding, 7= Placenta accreta 8=Other, (specify), 9= Unknown							
If “yes” is indicated for medications, please fill out Section R.							
<b>a. Date occurred</b>	<b>GA</b>	<b>Tri</b>	<b>Dx</b>	<b>Duration</b>  _____ <b>days</b>  99. • Unk	<b>Pain</b>  1. • Yes 2. • No (stated) 3. • Suspect 9. • Unknown	<b>Cramping</b>  1. • Yes 2. • No (stated) 3. • Suspect 9. • Unknown	<b>Medication given</b>  1. • Yes 2. • No 9. • Unknown
____/____/____ 99. • unknown							
<b>b. Date occurred</b>	<b>GA</b>	<b>Tri</b>	<b>Dx</b>	<b>Duration</b>  _____ <b>days</b>  99. • Unk	<b>Pain</b>  1. • Yes 2. • No (stated) 3. • Suspect 9. • Unknown	<b>Cramping</b>  1. • Yes 2. • No (stated) 3. • Suspect 9. • Unknown	<b>Medication given</b>  1. • Yes 2. • No 9. • Unknown
____/____/____ 99. • unknown							
<b>c. Date occurred</b>	<b>GA</b>	<b>Tri</b>	<b>Dx</b>	<b>Duration</b>  _____ <b>days</b>  99. • Unk	<b>Pain</b>  1. • Yes 2. • No (stated) 3. • Suspect 9. • Unknown	<b>Cramping</b>  1. • Yes 2. • No (stated) 3. • Suspect 9. • Unknown	<b>Medication given</b>  1. • Yes 2. • No 9. • Unknown
____/____/____ 99. • unknown							
<b>Comments:</b>							



STUDY ID Number:

<b>M. PRETERM LABOR</b> If "yes" is indicated for medications, please fill out Section R. <span style="float: right;"><input type="checkbox"/> No Info</span>				
a. Date reported  ___/___/___  99. • unknown	GA	Onset of s/s per patient  1. • No s/s 2. • <12h 3. • 12-24h 4. • >24h 99. • unknown	Signs/symptoms  • Uterine contractions • Cramping (per pt) • Cervical change • PROM • Other, (specify)_____ 99. • unknown	Treatments  • Meds (fill out sect. Q) • Bed rest • IV Hydration • Other, (specify)_____ 99. • unknown
b. Date reported  ___/___/___  99. • unknown	GA	Onset of s/s per patient  1. • No s/s 2. • <12h 3. • 12-24h 4. • >24h 99. • unknown	Signs/symptoms  • Uterine contractions • Cramping (per pt) • Cervical change • PROM • Other, (specify)_____ 99. • unknown	Treatments  • Meds (fill out sect. Q) • Bed rest • IV Hydration • Other, (specify)_____ 99. • unknown
c. Date reported  ___/___/___  99. • unknown	GA	Onset of s/s per patient  1. • No s/s 2. • <12h 3. • 12-24h 4. • >24h 99. • unknown	Signs/symptoms  • Uterine contractions • Cramping (per pt) • Cervical change • PROM • Other, (specify)_____ 99. • unknown	Treatments  • Meds (fill out sect. Q) • Bed rest • IV Hydration • Other, (specify)_____ 99. • unknown
d. Date reported  ___/___/___  99. • unknown	GA	Onset of s/s per patient  1. • No s/s 2. • <12h 3. • 12-24h 4. • >24h 99. • unknown	Signs/symptoms  • Uterine contractions • Cramping (per pt) • Cervical change • PROM • Other, (specify)_____ 99. • unknown	Treatments  • Meds (fill out sect. Q) • Bed rest • IV Hydration • Other, (specify)_____ 99. • unknown
e. Date reported  ___/___/___  99. • unknown	GA	Onset of s/s per patient  1. • No s/s 2. • <12h 3. • 12-24h 4. • >24h 99. • unknown	Signs/symptoms  • Uterine contractions • Cramping (per pt) • Cervical change • PROM • Other, (specify)_____ 99. • unknown	Treatments  • Meds (fill out sect. Q) • Bed rest • IV Hydration • Other, (specify)_____ 99. • unknown
<b>Comments:</b>  <div style="border: 1px solid black; height: 40px;"></div>				

STUDY ID Number:

**N. OTHER CONDITIONS OR TRAUMA ANYTIME DURING CURRENT PREGNANCY**  No Info

**Dx:** 1= Decreased fetal movement 2= Trauma/injury 3= Oligohydramnios 4= Polyhydramnios  
 5= IUGR 6= Macrosomia 7= loss of consciousness 8= Spontaneous reduction  
 88= other, (specify) 99= unknown

**If "yes" is indicated for medications, please fill out Section R.**

a. Date diagnosed ____/____/_____ 99. • unknown	GA	Tri	Dx	Description	Medication given 1. • Yes 2. • No 9. • Unknown
b. Date diagnosed ____/____/_____ 99. • unknown	GA	Tri	Dx	Description	Medication given 1. • Yes 2. • No 9. • Unknown
c. Date diagnosed ____/____/_____ 99. • unknown	GA	Tri	Dx	Description	Medication given 1. • Yes 2. • No 9. • Unknown
d. Date diagnosed ____/____/_____ 99. • unknown	GA	Tri	Dx	Description	Medication given 1. • Yes 2. • No 9. • Unknown

**Comments:**

STUDY ID Number:

<b>O. HOSPITAL ADMISSIONS/VISITS THIS PREGNANCY (INPATIENT AND OUTPATIENT)</b> For Medical History Code use Appendix If "yes" is indicated for medications, please fill out Section R. <span style="float: right;"><input type="checkbox"/> No Info</span>										
1. Treated in/as 1. • ER      2. • Outpatient 3. • Inpatient 9. • Unknown	Hospital/facility			Admit date ____/____/____			GA		Discharge date ____/____/____	
<b>Procedures:</b> 1. • X-rays, including dental 2. • Mammogram 3. • CT/CAT scans 4. • MRI/magnetic resonance 5. • Radionuclide study or scan 6. • Radiation treatments or scan 7. • Surgery 88. • Other: (Specify) 99. • unknown	<b>Dx1</b>	ICD9		ICD9		<b>Dx3</b>	ICD9	Treatment: 1. • Surgery 2. • Medications 8. • Other, (specify): _____ 99. • unknown		
		Problem	Problem	Problem						
		Medical History Code	Medical History Code	Medical History Code						
2. Treated in/as 1. • ER      2. • Outpatient 3. • Inpatient 9. • Unknown	Hospital/facility			Admit date ____/____/____			GA		Discharge date ____/____/____	
<b>Procedures:</b> 1. • X-rays, including dental 2. • Mammogram 3. • CT/CAT scans 4. • MRI/magnetic resonance 5. • Radionuclide study or scan 6. • Radiation treatments or scan 7. • Surgery 88. • Other: (Specify) 99. • unknown	<b>Dx1</b>	ICD9		ICD9		<b>Dx3</b>	ICD9	Treatment: 1. • Surgery 2. • Medications 8. • Other, (specify): _____ 99. • unknown		
		Problem	Problem	Problem						
		Medical History Code	Medical History Code	Medical History Code						
3. Treated in/as 1. • ER      2. • Outpatient 3. • Inpatient 9. • Unknown	Hospital/facility			Admit date ____/____/____			GA		Discharge date ____/____/____	
<b>Procedures:</b> 1. • X-rays, including dental 2. • Mammogram 3. • CT/CAT scans 4. • MRI/magnetic resonance 5. • Radionuclide study or scan 6. • Radiation treatments or scan 7. • Surgery 88. • Other: (Specify) 99. • unknown	<b>Dx1</b>	ICD9		ICD9		<b>Dx3</b>	ICD9	Treatment: 1. • Surgery 2. • Medications 8. • Other, (specify): _____ 99. • unknown		
		Problem	Problem	Problem						
		Medical History Code	Medical History Code	Medical History Code						
4. Treated in/as 1. • ER      2. • Outpatient 3. • Inpatient 9. • Unknown	Hospital/facility			Admit date ____/____/____			GA		Discharge date ____/____/____	
<b>Procedures:</b> 1. • X-rays, including dental 2. • Mammogram 3. • CT/CAT scans 4. • MRI/magnetic resonance 5. • Radionuclide study or scan 6. • Radiation treatments or scan 7. • Surgery 88. • Other: (Specify) 99. • unknown	<b>Dx1</b>	ICD9		ICD9		<b>Dx3</b>	ICD9	Treatment: 1. • Surgery 2. • Medications 8. • Other, (specify): _____ 99. • unknown		
		Problem	Problem	Problem						
		Medical History Code	Medical History Code	Medical History Code						
<b>Comments:</b>										

STUDY ID Number:

<b>P. PRENATAL PROCEDURES</b>		<input type="checkbox"/> No Info
<b>Procedure</b>		
Fetal echocardiogram	Date: __/__/____	1. • normal 2. • abnormal 99. • unknown
External version	# attempts:	1. • successful 2. • unsuccessful 99. • unknown
Fetal reduction	Date: __/__/____	1. • # fetuses originally _____ 2. • # fetuses remaining _____
Cerclage	Date placed : __/__/____ Date removed: __/__/____	
Fetal Transfusion	Date: __/__/____	Reason:
Fetal Surgery	Date: __/__/____	Type/Description
Nonstress test (NST)	Date: __/__/____ Date: __/__/____	Findings: 1) 2)
Contraction stress test (CST)	Date: __/__/____	Findings:
Other (specify) _____	Date: __/__/____	
<b>Comments:</b>		

<b>Q. MEDICAL HISTORY</b>					<input type="checkbox"/> No Info
<p><b>Medical History:</b> Use codes from Medical History List (Appendix )</p> <p>If “yes” is indicated for medications, please fill out Section R.</p>					
No.	Medical Condition Code (and specify)	Precision Code	Time Period Condition Active (CHECK ALL THAT APPLY)	Date/Age at First Diagnosis	Medication Given
1		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk
2		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk
3		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk
4		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk

**Q. MEDICAL HISTORY** No Info**Medical History:** Use codes from Medical History List (Appendix )

If "yes" is indicated for medications, please fill out Section R.

No.	Medical Condition Code (and specify)	Precision Code	Time Period Condition Active (CHECK ALL THAT APPLY)	Date/Age at First Diagnosis	Medication Given
5		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk
6		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk
7.		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk
8.		1. •Suspected 2. •Definite 9. • Unknown	1 • Active before index pregnancy 2 • Active during 1 <sup>st</sup> trimester (1-13 weeks GA) 3 • Active during 2 <sup>nd</sup> trimester (14- 26 weeks GA) 4 • Active during 3 <sup>rd</sup> trimester (27-40+ weeks GA) 5 • Active during index pregnancy, trimester unknown 9• Not stated/unknown	Date: ___/___/_____ Age: ___ 9. <input type="checkbox"/> unknown	1. • Yes 2. • No 9. • Unk

**COMMENTS:**

STUDY ID Number:

STUDY ID Number:

**R. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES ,STEROIDS, HORMONES, AND OTHER MEDICATIONS) GIVEN DURING PREGNANCY-**

Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'  No Info **different amts?**

**Drug codes:** 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics, 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention,88= other (specify), 99= unknown

**Exclusions:** laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, tylenol, methergine

**Reason:** 3 = lung maturity, 4= cervical ripening, 5= maternal disease, 6= prophylaxis 7= maternal fever 8= positive culture, 9= pain relief, 10= hyperemesis, 11= PIH, 88= other (specify), 99= unknown

Refer	Code	Drug name	Reason	Start Date	Duration (in days)	Dose	Unit	Freq	Entire pregnancy
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•



STUDY ID Number:

**R. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES ,STEROIDS, HORMONES, AND OTHER MEDICATIONS) GIVEN DURING PREGNANCY (cont'd)**

Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'

**Drug codes:** 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics, 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention, 88= other (specify), 99= unknown

**Exclusions:** laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, tylenol, methergine

**Reason:** 3 = lung maturity, 4= cervical ripening, 5= maternal disease, 6= prophylaxis 7= maternal fever 8= positive culture, 9= pain relief, 10= hyperemesis, 11= PIH, 88= other (specify), 99= unknown

Refer	Code	Drug name	Reason	Start Date	Duration (in days)	Dose	Unit	Freq	Entire preg.
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•

STUDY ID Number:

**R. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES ,STEROIDS, HORMONES, AND OTHER MEDICATIONS) GIVEN DURING PREGNANCY (cont'd)**

Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'

**Drug codes:** 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics, 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention, 88= other (specify), 99= unknown

**Exclusions:** laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, tylenol, methergine

**Reason:** 3 = lung maturity, 4= cervical ripening, 5= maternal disease, 6= prophylaxis 7= maternal fever 8= positive culture, 9= pain relief, 10= hyperemesis, 11= PIH, 88= other (specify), 99= unknown

Refer	Code	Drug name	Reason	Start Date	Duration (in days)	Dose	Unit	Freq	Entire preg.
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				___/___/___ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•

STUDY ID Number:

**R. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES ,STEROIDS, HORMONES, AND OTHER MEDICATIONS) GIVEN DURING PREGNANCY (cont'd)**

Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'

**Drug codes:** 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics, 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention, 88= other (specify), 99= unknown

**Exclusions:** laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, tylenol, methergine

**Reason:** 3 = lung maturity, 4= cervical ripening, 5= maternal disease, 6= prophylaxis 7= maternal fever 8= positive culture, 9= pain relief, 10= hyperemesis, 11= PIH, 88= other (specify), 99= unknown

Refer	Code	Drug name	Reason	Start Date	Duration (in days)	Dose	Unit	Freq	Entire preg.
				____/____/____ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/____ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/____ 99. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•

**Comments:**