

Prenatal Care Medical Record Abstraction Form

This form should be used for abstraction of medical records from **all prenatal care providers** seen during **index pregnancy**, as well as medical records from **other providers** that provided care for the **biological mother** in the **3 years preceding the pregnancy with the index child**.

These other providers include internists, infertility treatment providers, psychiatrists and other mental health care providers, allergists, immunologists, etc.

A single abstraction form should be used for all relevant providers.

Notes: if a record from an infertility treatment provider is received and reviewed, additional details of treatments just before the index pregnancy should be recorded in various appendices as indicated.

Below list all providers that contributed data to this form.

OF NOTE: It is NOT necessary to indicate the specific provider record source for each individual data item on this form. It will be too cumbersome to try and detail exactly which record(s) provided which data. Hopefully, in most cases if the same information is provided in multiple different provider records, it will be consistent and complimentary. However, there might be cases in which conflicting information is presented in 2 different records. Use the data available to make your best judgment about the correct information and then add a comment providing details of the conflict between provider sources.

CONTRIBUTING PROVIDERS			(Extra sheets in Appendix A if necessary)		
A.1. Name of Provider/Hospital					
A.2. Street Address					
A.3. City			A.4. State		A.5. Zip Code
ABSTRACTION LOG					
A.6. Date __/__/____		A.7. Date __/__/____		A.8. Date __/__/____	
A.6.1 to A.6.8 Time <i>(*use military time)</i>		A.7.1 to A.7.8 Time <i>(*use military time)</i>		A.8.1 to A.8.8 Time <i>(*use military time)</i>	
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
A.9. Date __/__/____		A.10. Date __/__/____		A.11. Date __/__/____	
A.9.1 to A.9.8 Time <i>(*use military time)</i>		A.10.1 to A.10.8 Time <i>(*use military time)</i>		A.11.1 to A.11.8 Time <i>(*use military time)</i>	
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____
Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____	Start ____: ____	Stop ____: ____

B.1. Name of Provider/Hospital					
B.2. Street Address					
B.3. City			B.4. State		B.5. Zip Code
ABSTRACTION LOG					
B.6. Date ____/____/____		B.7. Date ____/____/____		B.8. Date ____/____/____	
B.6.1 to B.6.8 Time (*use military time)		B.7.1 to B.7.8 Time (*use military time)		B.8.1 to B.8.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
B.9. Date ____/____/____		B.10. Date ____/____/____		B.11. Date ____/____/____	
B.9.1 to B.9.8 Time (*use military time)		B.10.1 to B.10.8 Time (*use military time)		B.11.1 to B.11.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
C.1. Name of Provider/Hospital					
C.2. Street Address					
C.3. City			C.4. State		C.5. Zip Code
ABSTRACTION LOG					
C.6. Date ____/____/____		C.7. Date ____/____/____		C.8. Date ____/____/____	
C.6.1 to C.6.8 Time (*use military time)		C.7.1 to C.7.8 Time (*use military time)		C.8.1 to C.8.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
C.9. Date ____/____/____		C.10. Date ____/____/____		C.11. Date ____/____/____	
C.9.1 to C.9.8 Time (*use military time)		C.10.1 to C.10.8 Time (*use military time)		C.11.1 to C.11.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____

D.1. Name of Provider/Hospital					
D.2. Street Address					
D.3. City			D.4. State		D.5. Zip Code
ABSTRACTION LOG					
D.6. Date ____/____/____		D.7. Date ____/____/____		D.8. Date ____/____/____	
D.6.1 to D.6.8 Time (*use military time)		D.7.1 to D.7.8 Time (*use military time)		D.8.1 to D.8.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
D.9. Date ____/____/____		D.10. Date ____/____/____		D.11. Date ____/____/____	
D.9.1 to D.9.8 Time (*use military time)		D.10.1 to D.10.8 Time (*use military time)		D.11.1 to D.11.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
E.1. Name of Provider/Hospital					
E.2. Street Address					
E.3. City			E.4. State		E.5. Zip Code
ABSTRACTION LOG					
E.6. Date ____/____/____		E.7. Date ____/____/____		E.8. Date ____/____/____	
E.6.1 to E.6.8 Time (*use military time)		E.7.1 to E.7.8 Time (*use military time)		E.8.1 to E.8.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
E.9. Date ____/____/____		E.10. Date ____/____/____		E.11. Date ____/____/____	
E.9.1 to E.9.8 Time (*use military time)		E.10.1 to E.10.8 Time (*use military time)		E.11.1 to E.11.8 Time (*use military time)	
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____
Start ____:____	Stop ____:____	Start ____:____	Stop ____:____	Start ____:____	Stop ____:____

(Add extra sheets as needed)

Study ID Number _____ # continuation sheets for this section (enter only on first page of section) _____

A. IDENTIFYING INFORMATION			<input type="checkbox"/> No information for any item in section
1. Mother's Name (Last, First, Middle)		2. Study ID#	
3. Maiden Name	4. AKA	5. Mother's DOB	
6. Street Address			
7. City	8. State	9. Zip Code	
10. Delivery Hospital		11. Delivery Hospital Address	
12. City	13. State	14. Zip Code	
Comments:			

A. IDENTIFYING INFORMATION (continued)		
Maternal Address History (List in reverse chronological order)		
15. Date __/__/____ (last known at this address)	16. Mother's Street Address	
17. City	18. State	19. Zip Code
20. Date __/__/____ (last known at this address)	21. Mother's Street Address	
22. City	23. State	24. Zip Code
25. Date __/__/____ (last known at this address)	26. Mother's Street Address	
27. City	28. State	29. Zip Code
30. Date __/__/____ (last known at this address)	31. Mother's Street Address	
32. City	33. State	34. Zip Code
35. Date __/__/____ (last known at this address)	36. Mother's Street Address	
37. City	38. State	39. Zip Code
40. Date __/__/____ (last known at this address)	41. Mother's Street Address	
42. City	43. State	44. Zip Code
45. Date __/__/____ (last known at this address)	46. Mother's Street Address	
47. City	48. State	49. Zip Code
Comments:		

Sections B-Q: How to Document Various Types of Missing Information

A. No information -- entire section

Each section of each form will include either one or two universal missing check boxes. If either are checked, no further data are recorded for the entire section.

1. No information for any item in section

Checked if:

No relevant tests or procedures appear to have been ordered by any contributing medical care providers; and/or
No information was recorded for relevant health status, medical conditions, medications.

2. Test/procedure for one or more items in section indicated but no information on dates, results, etc.
(will only apply to certain sections as indicated)

B. Information available for one or more items within a section BUT no information for selected items

If there is information in the chart for one or more items in a given section on a given abstraction form, all pertinent data should be recorded. However, there is still the possibility that there will be missing data within these sections. Three types of missing data codes are recognized:

NA – NOT APPLICABLE (for use with certain items such as those with skip patterns and those for which multiple tests/procedures/etc. might have been performed and all are requested in abstraction form. After last relevant item is recorded, the subsequent item on abstract form is NA to indicate the end of reporting).

IL -- NOT LEGIBLE (self-explanatory)

NR – NO info in RECORD (“true missing” There ***should*** be information for an item, but it cannot be located.)

The following coding schemes will be applied to code these 3 types of missing:

Categorical variables with a finite coding scheme

77 NA

88 IL

99 NR

Dates and times – these may be completely missing or partially missing.

Data entry format is ___/___/___ and ___:___

For dates and time (military hours and minutes)

For day, month, hours, and minutes, enter **77, 88, or 99** as appropriate

For year the enter **7777, 8888, or 9999** as appropriate

Thus, these can be completely missing or mixed with valid data such as:

03/99/2003 and 10:88

Continuous/open ended data items: Since it will be overly burdensome to develop and employ a missing data scheme which individually considers each data item and the appropriate number of digits for missing values use the alpha codes for missing in these instances:

NA, IL, or NR

B. MENSTRUAL HISTORY, CONCEPTION, INFERTILITY, PRENATAL CARE				
<input type="checkbox"/> No information for any item in section				
1. Date of first PNV __/__/____		2. Date of last PNV __/__/____		3. Total # of Visits ____ <i>Record IL or NR as relevant</i>
4. LMP Date __/__/____	5. LMP Date Certain 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> Not Recorded		6. EDC – LMP __/__/____	7. EDC – US __/__/____
8. Number of months index pregnancy attempted _____ Months OR <input type="checkbox"/> Not Planned <i>Record IL or NR as relevant</i>		9. Contraception in use at time of conception 1 <input type="checkbox"/> none/rhythm 2 <input type="checkbox"/> barrier/chemical 3 <input type="checkbox"/> hormonal 4 <input type="checkbox"/> IUD 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> Not recorded		10. Date contraception stopped __/__/____
11. Menstrual History Age of onset _____ <i>Record IL or NR as relevant</i>	12. Menstrual Cycles 1 <input type="checkbox"/> regular 2 <input type="checkbox"/> irregular 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> Not recorded	13. Intercycle Interval _____ Days <i>If range provided, record midpoint. Record IL or NR as relevant</i>	14. Duration _____ Days <i>(If range provided, record midpoint) Record IL or NR as relevant</i>	
15. Any indication of infertility problems and/or treatments prior to or at the time of the index pregnancy? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 88 <input type="checkbox"/> Illegible <i>If no</i> , skip to section C. <i>If yes</i> , complete items 16 (diagnoses), 17 (treatment history prior to index pregnancy) and 18 (conception/treatment index pregnancy). If unsure where to place a given treatment (because dates of treatment are not clear), record in 18 with “Maybe” Box (18c) checked. If records from infertility providers available, complete Section Q or Appendix C for treatment details index pregnancy.				
16. Infertility Disorders/Diagnoses 17. Treatment History (Prior to Index Pregnancy)				
17a. Codes for treatment type: 1=ovulation induction medications; 2=other (non-ovulation) medications mother; 3= medication for mother indicated but type NOT indicated or abstractor unsure; 4= IUI or artificial insemination; 5=Assisted Reproductive Technology (ART) procedure; 6= surgery mother; 7=medication/procedure/surgery father; 8=other infertility treatment; 9= treatment indicated but type not specified; 77 NA; 88 Illegible				
PAST DISORDERS/DIAGNOSES		PAST TREATMENTS/MEDICATIONS <i>(Treatments do not need to correspond with specific diagnoses. List in reverse chronological order. Extra sheet provided in Appendix A)</i>		
16a. 1 – 16a.8 Check all that apply	16b. 1 – 16b.8 Date First Diagnosed (mm/yyyy OR yyyy)	17a. 1– 17a.x Treatment Code	17b. 1– 17b.x Specifications	17c. 1– 17c.x Treatment Date* (mm/yyyy OR yyyy)
<input type="checkbox"/> Tubal infertility	__/__/____			__/__/____
<input type="checkbox"/> Ovulatory dysfunction or Polycystic Ovaries (PCO)	__/__/____			__/__/____
<input type="checkbox"/> Diminished ovarian reserve/ premature ovarian failure/infertility resulting from advanced maternal age	__/__/____			__/__/____
<input type="checkbox"/> Endometriosis	__/__/____			__/__/____
<input type="checkbox"/> Structural uterine abnormalities	__/__/____			__/__/____
<input type="checkbox"/> Male Factor	__/__/____			__/__/____
<input type="checkbox"/> Unexplained or Idiopathic Infertility specifically noted	__/__/____			__/__/____
<input type="checkbox"/> Infertility noted but no info on specific diagnosis (including idiopathic)	__/__/____			__/__/____
Comments:		Comments:		

*Record only treatments earlier than time periods indicated in #18

B. MENSTRUAL HISTORY, CONCEPTION, INFERTILITY, PRENATAL CARE (continued)				
18. Mode of Conception and Infertility Treatment Index Pregnancy*				
Treatments Prior to Index Pregnancy (check all that apply)	18a.1 - 18a.9 Yes	18b.1 - 18b.7 Maybe**	18c.1 -18c.7 Medications/Treatments Specifications	18d.1 -18d.7 Dates
1. Ovulation induction medication (OI) (Started within 3 months of conception)*	<input type="checkbox"/>	<input type="checkbox"/>	Specify medication(s) If infertility treatment provider record available for Non-ART treatments, provide medication details in Section Q . Note, infertility treatment provider might be same as prenatal care provider.	___/___/____
2. Other medication(s) taken by mother (within 3 months of conception)*	<input type="checkbox"/>	<input type="checkbox"/>	Specify medication(s) If infertility treatment provider record available for Non-ART treatments, provide medication details in Section Q . Note, infertility treatment provider might be same as prenatal care provider.	___/___/____
3. Intrauterine insemination (IUI)/artificial insemination (within 1 month of conception)*	<input type="checkbox"/>	<input type="checkbox"/>	Provide related details	___/___/____
4. Assisted reproductive technology (ART) (eg in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI)) (any stage of procedure within 1 month of conception)* <i>Note: All stages in an ART treatment might occur over >4 weeks</i>	<input type="checkbox"/>	<input type="checkbox"/>	Record any additional info from prenatal care record in Appendix B (short form) and info from ART provider record in Appendix C (long form).	___/___/____
5. Mother had surgery for infertility disorder (eg tubal surgery) (within 6 months of conception)*	<input type="checkbox"/>	<input type="checkbox"/>	Specify type of surgery	___/___/____
6. Father had medication, surgery or other treatment for an infertility-related disorder (such as hormonal imbalance or varicocele) (within 6 months of conception)*	<input type="checkbox"/>	<input type="checkbox"/>	Specify type of treatment(s)/medication(s)/surgery(ies)	___/___/____
7. Assisted conception indicated for index pregnancy but treatment type not provided	<input type="checkbox"/>	<input type="checkbox"/>	Provide related details	___/___/____
*If available B4 . LMP Date should be used to determine start of pregnancy in calculating intervals specified above. In some cases LMP or treatment date might be missing, but provider notation will indicate that treatment occurred within the specified interval. **Maybe: In some cases an infertility treatment might be noted but the date of treatment is not recorded and the notation in the record is not clear as to whether the treatment occurred in the specified interval; thus, the abstractor will not be able to determine if treatment was within timeframe of just before index pregnancy and should check the Maybe box.				
8. Infertility problem indicated but index pregnancy conceived without assistance	<input type="checkbox"/>			
9. Cannot determine if natural or assisted conception	<input type="checkbox"/>			
COMMENTS:				

C. PREGNANCY HISTORY UP TO AND INCLUDING INDEX PREGNANCY

No information for any item in section

1. TOTAL Pregnancies	2. Full Term Birth (still + live)	3. Premature Birth (still + live)	4. Stillbirths	5. Live births	6. Ab – Induced	7. Ab – Spontaneous	8. Ectopic	9. Multiple Births (still +live)
-----------------------------	-----------------------------------	-----------------------------------	----------------	----------------	-----------------	---------------------	------------	----------------------------------

****Use the following codes to complete the table below****(If needed, extra sheet provided in Appendix A)

Pregnancy Number/Baby Number	Outcome	Plurality	Birth Weight	Sex	Type Delivery
Number past pregnancies in reverse chronological order (most recent = 1). If plurality 77, 88 or 99, baby number not needed. For singletons enter 1/1. For pregnancies specified as multiple gestations, list each fetus/infant born separately. E.g. 1/1, 1/2, 1/3, pertain to infants 1, 2, and 3 from pregnancy 1.	1. Live Birth 2. Stillbirth 3. Induced Abortion 4. Spontaneous Abortion 5. Ectopic Pregnancy 6. Molar Pregnancy 7. Maternal Death prior to Birth 8. other specify 88. IL 99. NR	1. Singleton 2. Twin 3. Triplet 4. Quad 5. Quint Etc.... 77. NA (outcomes 3-8) 88. IL 99. NR	Grams preferred, if available Not applicable for outcomes 3-8, record NA Record IL or NR for other missing values as needed.	1. Male 2. Female 3. Ambiguous 77. NA (outcomes 3-8) 88. IL 99. NR	1. Vaginal 2. Primary C-Section 3. Secondary C-Section 4. VBAC 77. NA (outcomes 3-8) 88. IL 99. NR

Prenatal, Delivery, Post Partum Problems/Complications

1. No complications specifically noted	15. Macrosomia
2. Abruptio placentae	16. Placenta previa
3. Birth defect (specify if yes)	17. Postpartum depression
4. Cephalopelvic disproportion	18. Postpartum hemorrhage
5. Chorioamnionitis	19. Pregnancy induced hypertension/ preeclampsia/gestational hypertension
6. Deep vein thrombosis	20. Premature rupture of membranes (PROM)
7. Eclampsia	21. Preterm labor
8. Fetal reduction	22. Pulmonary edema
9. Gestational Diabetes	23. Pulmonary embolus (PE)
10. HELLP	24. Uterine rupture
11. Hyperemesis	25. Vaginal bleeding
12. Infant Death, neonatal (<28 days)	26. Other: specify
13. Infant Death, post-neonatal (28 days – 1 year)	99. Unknown/ Not documented
14. Intrauterine growth restriction/retardation (IUGR)	

10a.1preg – 10a.20preg	10b.1 – 10b.20	10c.1 – 10c.20	10d.1 – 10d.20	10e.1 – 10e.20	10f.1 – 10f.20	10g.1 – 10g.20 OR 10h.1 – 10h.20 (lb) 10i.1 – 10i.20 (oz)	10j.1 – 10j.20	10k.1 – 10k.20	10L.1.1 – 10L.20.28
AND 10a.1baby – 10a.20baby			Outcome Month	Outcome Year	GA	Birth Weight	Sex	Type Delivery	(Each complication will be a separate y/n variable for each pregnancy+ other specify and NR) Complications with mother/infant (record codes; specify detail for “other”)
Preg # Baby #	Outcome	Plurality	Mm	yyyy	Wks	g lbs/oz			

COMMENTS: Provide indication of preg no/baby no for each comment.

D. MATERNAL MEASUREMENTS INDEX PREGNANCY (Extra sheets in Appendix A if necessary)
 No information for any item in section
 Test/procedure for one or more items in section indicated but no information on dates, results, etc.

1. Pre-Pregnancy weight **1a.** ____ .____ **1b** Unit: 1. pounds 2. kg 88. Illegible 99. NR

2. Date of Pre-Pregnancy weight **2a.** __/__/____ OR **2b.** self-reported

3. Maternal height **3a.** ___ ft **3b** ____ in OR **3c.** ____ cm OR **3d.** Illegible Not Recorded

4. PRENATAL VISITS Record IL or NR for missing information

4a.1 – 4a.26 Visit No	4b1 – 4b.26 Date mm/dd/yyyy	4c1 – 4c.26 Wks Gestation (provider's best estimate)	4d1 – 4d.26 4e1 – 4e.26 Fundal Ht <input type="checkbox"/> cm <input type="checkbox"/> inches <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	4f1 – 4f.26 Fetal Heart Rate	4g1 – 4g.26 Preterm labor signs/ symptoms*	4h1 – 4h.26 4i1 – 4i.26 Blood Pressure Systolic Diastolic	4j1 – 4j.26 4k1 – 4k.26 Weight <input type="checkbox"/> Lb <input type="checkbox"/> <input type="checkbox"/> kg <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	4L1 – 4L.26 4m1 – 4m.26 Urine +albumin <input type="checkbox"/> <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	+glucose <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)
1 first					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
__ last					<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

5. HOSPITAL DELIVERY ADMISSION(S) Record IL or NR for missing information

5a.1 – 5a.3 Date mm/dd/yyyy	5b.1 – 5b.3 Weeks Gestation (provider's best estimate)	5c.1 – 5d.3 5d.1 – 5d.3 Fundal Ht <input type="checkbox"/> cm <input type="checkbox"/> inches <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	5e.1 – 5e.3 Fetal Heart Rate	5f.1 – 5f.3 Preterm labor signs/ symptoms*	5g.1 – 5g.3 5h.1 – 5h.3 Blood Pressure Systolic Diastolic	5i.1 – 5i.3 5j.1 – 5j.3 Weight <input type="checkbox"/> Lb <input type="checkbox"/> kg <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	5k.1 – 5k.3 5L.1 – 5L.3 Urine +albumin <input type="checkbox"/> <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	+glucose <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (al)
				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

* If preterm labor signs/symptoms are present, provide details in Section L.

COMMENTS: Indicate visit no and date.

E. BLOOD TYPE, SCREENING, AND OTHER REPORTS (excluding cultures/rapid strep screens) INDEX PREGNANCY					
<input type="checkbox"/> No information for any item in section					
1a. Blood Type 1b. Rh 1. <input type="checkbox"/> negative 2. <input type="checkbox"/> positive 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 1c. Date ___/___/____	2a. Antibody Screen 1. <input type="checkbox"/> negative 2. <input type="checkbox"/> positive 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 2b. Date ___/___/____	3a. RPR/VDRL 1. <input type="checkbox"/> negative 2. <input type="checkbox"/> positive 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 3b. Date ___/___/____	4a. HbsAG 1. <input type="checkbox"/> negative 2. <input type="checkbox"/> positive 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 4b. Date ___/___/____	5a. Rubella Titer 1. <input type="checkbox"/> immune 2. <input type="checkbox"/> non-immune 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 5b. Date ___/___/____	6a. HIV 1. <input type="checkbox"/> negative 2. <input type="checkbox"/> positive 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 6b. Date ___/___/____
7a. Chlamydia Screen 1. <input type="checkbox"/> negative 2. <input type="checkbox"/> positive 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 7b. Date ___/___/____	8a. Diabetes Screen (1 hour) 1. <input type="checkbox"/> NL 2. <input type="checkbox"/> ABNL 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 8b. Date ___/___/____	9. Glucose Tolerance Tests 9a. FBS 1. <input type="checkbox"/> NL 2. <input type="checkbox"/> ABNL 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 9b. Date ___/___/____	9c. 1 hour 1. <input type="checkbox"/> NL 2. <input type="checkbox"/> ABNL 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	9d. 2 hour 1. <input type="checkbox"/> NL 2. <input type="checkbox"/> ABNL 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	9e. 3 hour 1. <input type="checkbox"/> NL 2. <input type="checkbox"/> ABNL 3. <input type="checkbox"/> tested, results unknown 4. <input type="checkbox"/> not tested 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR 9f <input type="checkbox"/> more than one GTT – record additional GTT results in #22
HGB (g/dL) 10a.1 OR <input type="checkbox"/> tested, results unknown <input type="checkbox"/> not tested <input type="checkbox"/> Illegible <input type="checkbox"/> NR 10a.2. Date ___/___/____	HGB (g/dL) 10b.1 OR <input type="checkbox"/> tested, results unknown <input type="checkbox"/> not tested <input type="checkbox"/> Illegible <input type="checkbox"/> NR 10b.2. Date ___/___/____	HGB (g/dL) 10c.1 OR <input type="checkbox"/> tested, results unknown <input type="checkbox"/> not tested <input type="checkbox"/> Illegible <input type="checkbox"/> NR 10c.2. Date ___/___/____	HCT (%) 11a.1 OR <input type="checkbox"/> tested, results unknown <input type="checkbox"/> not tested <input type="checkbox"/> Illegible <input type="checkbox"/> NR 11a.2. Date ___/___/____	HCT (%) 11b.1 OR <input type="checkbox"/> tested, results unknown <input type="checkbox"/> not tested <input type="checkbox"/> Illegible <input type="checkbox"/> NR 11b.2. Date ___/___/____	HCT (%) 11c.1 OR <input type="checkbox"/> tested, results unknown <input type="checkbox"/> not tested <input type="checkbox"/> Illegible <input type="checkbox"/> NR 11c.2. Date ___/___/____

E. BLOOD TYPE, SCREENING, AND OTHER REPORTS (excluding cultures/rapid strep screens) (continued)

<p>12a. HGB electrophoresis</p> <p>1. <input type="checkbox"/> tested 2. <input type="checkbox"/> declined 3. <input type="checkbox"/> tested but results unknown 4. <input type="checkbox"/> not tested, unknown if offered test 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p> <p>12b. Date ___/___/_____</p>	<p>12c. Results (Hb):</p> <p><input type="checkbox"/> AA <input type="checkbox"/> SS <input type="checkbox"/> AS <input type="checkbox"/> SC <input type="checkbox"/> AC <input type="checkbox"/> AF <input type="checkbox"/> A₂</p> <p><input type="checkbox"/> NA <input type="checkbox"/> Illegible <input type="checkbox"/> NR</p>	<p>13a. Progesterone Level</p> <p>1. <input type="checkbox"/> tested 2. <input type="checkbox"/> declined 3. <input type="checkbox"/> tested but results unknown 4. <input type="checkbox"/> not tested, unknown if offered test 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p> <p>13b. Date ___/___/_____</p> <p>13c. Results _____ ng/ml</p> <p>13d. <input type="checkbox"/> more than one test – record additional results in #22</p>
---	--	---

15. Maternal Serum Screening (MS-AFP, Triple Screen, Quad Screen, or First Tri Screening) results

<p>15a.1</p> <p>Date ___/___/_____</p>	<p>15b.1 <u>Test:</u> _____</p> <p>1. <input type="checkbox"/> MS-AFP 2. <input type="checkbox"/> Triple Screen 3. <input type="checkbox"/> Quad Screen 4. <input type="checkbox"/> 1st Trimester Screen</p> <p>5. <input type="checkbox"/> redraw/recalculated</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p><u>Results:</u></p> <p>15c.1.1</p> <p>1. <input type="checkbox"/> screen negative 2. <input type="checkbox"/> screen positive 3. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p> <p>15c.1.2 FOR: 1. <input type="checkbox"/> Trisomy 18 2. <input type="checkbox"/> Trisomy 21 3. <input type="checkbox"/> ONTD 4. <input type="checkbox"/> abn. high levels 5. <input type="checkbox"/> abn. low levels</p> <p>OR 15c.1.3, 15c.1.4</p> <p>1 in _____ chance for</p> <p>1. <input type="checkbox"/> Trisomy 18 2. <input type="checkbox"/> Trisomy 21 3. <input type="checkbox"/> ONTD</p>	<p><u>Numeric Results (if present):</u> 15d.1.1 to 15d.1.11</p> <p>MS-AFP: _____ MoM or _____ ng/mL uE₃: _____ MoM or _____ ng/mL hCG: _____ MoM or _____ ng/mL PAPP-A: _____ MoM or _____ ng/mL Inhibin A or DIA: _____ MoM or _____ ng/mL</p> <p>Nuchal Translucency (NT): _____ mm</p>
--	--	---	--

<p>15a.2</p> <p>Date ___/___/_____</p>	<p>15b.2 <u>Test:</u> _____</p> <p>1. <input type="checkbox"/> MS-AFP 2. <input type="checkbox"/> Triple Screen 3. <input type="checkbox"/> Quad Screen 4. <input type="checkbox"/> 1st Trimester Screen</p> <p>5. <input type="checkbox"/> redraw/recalculated</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p><u>Results:</u></p> <p>15c.2.1</p> <p>1. <input type="checkbox"/> screen negative 2. <input type="checkbox"/> screen positive 3. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p> <p>15c.2.2 FOR: 1. <input type="checkbox"/> Trisomy 18 2. <input type="checkbox"/> Trisomy 21 3. <input type="checkbox"/> ONTD 4. <input type="checkbox"/> abn. high levels 5. <input type="checkbox"/> abn. low levels</p> <p>OR 15c.2.3, 15c.2.4</p> <p>1 in _____ chance for</p> <p>1. <input type="checkbox"/> Trisomy 18 2. <input type="checkbox"/> Trisomy 21 3. <input type="checkbox"/> ONTD</p>	<p><u>Numeric Results (if present):</u> 15d.2.1 to 15d.2.11</p> <p>MS-AFP: _____ MoM or _____ ng/mL uE₃: _____ MoM or _____ ng/mL hCG: _____ MoM or _____ ng/mL PAPP-A: _____ MoM or _____ ng/mL Inhibin A or DIA: _____ MoM or _____ ng/mL</p> <p>Nuchal Translucency (NT): _____ mm</p>
--	--	---	--

E. BLOOD TYPE, SCREENING, AND OTHER REPORTS (excluding cultures/rapid strep screens) (continued)

16. Chorionic Villi Sampling (CVS) Procedure
16a.
 Outcome of Procedure:
 1. tested (see results)
 2. tested, results unknown
 3. not tested – not enough sample
 4. not tested
 88. Illegible
 99. NR
16b. Date
 __ / __ / ____

Test results from CVS:
16c. Karyotype:

 Genetic tests (**16d-16i**):
 Name: _____ Result: _____

17. Amniocentesis Procedure
17a.
 Outcome of Procedure:
 1. tested (see results)
 2. tested, results unknown
 3. not tested – not enough sample
 4. not tested
 88. Illegible
 99. NR
17b Date
 __ / __ / ____

Test results from amniocentesis:
17c Karyotype:

 Genetic tests (**17d-17i**):
 Name: _____ Result: _____

18. Second Amniocentesis Procedure
18a
 Outcome of Procedure:
 1. tested (see results)
 2. tested, results unknown
 3. not tested – not enough sample
 4. not tested
 88. Illegible
 99. NR
18b Date
 __ / __ / ____

Test results from amniocentesis:
18c Karyotype:

 Genetic tests (**18d-18i**):
 Name: _____ Result: _____

19. AFP and AChE (Direct from amnio fluid NOT maternal serum)
19a.
 Outcome of Procedure:
 1. tested (see results)
 2. tested, results unknown
 3. not tested – not enough sample
 4. not tested
 88. Illegible
 99. NR
19b. Date
 __ / __ / ____

AFP & AChE Results:
19c.
 1. negative
 2. positive
19d.
 FOR:
 1. ONTD
 2. abn. high levels
 3. abn. low levels
 OR
19e.1-19e.5
 1 in ____ chance for
 ONTD
 AF-AFP:
 _____ MoM or _____ ng/mL
 AChE:
 _____ MoM or _____ ng/mL

20. Amnio Gram Stain
20a. Outcome
 1. tested (see results)
 2. tested, results unknown
 3. not tested – not enough sample
 4. not tested
 88. Illegible
 99. NR
20b. Date
 __ / __ / ____

20c. Results
 1. negative
 2. positive
 88. Illegible
 99. NR

21. Amnio Lung Maturity
21a **21b** **21c**
 LS _____ PG _____ FSI _____
21d Date
 __ / __ / ____

E. BLOOD TYPE, SCREENING, AND OTHER REPORTS (excluding cultures/rapid strep screens) (continued)

22. Other Lab Reports (except cultures: to be reported in Section I) Extra sheet provided in Appendix A if needed

22a.1-22a.20	22b.1-22b.20	22c.1-22c.20 (22c.[1-20].oth.sp)	22d.1-22d.20 Normal Lab Range (if available)	22e.1-22e.20
Test Date	Test Name/Description	Results		Comments
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		

COMMENTS: Indicate item #

F. PREGNANCY ULTRASOUND REPORTS INDEX PREGNANCY

(Extra sheet provided in Appendix A if needed)

No information for any item in section

Test/procedure for one or more items in section indicated but no information on dates, results, etc.

<p>1a. Date of scan</p> <p>___/___/_____</p>	<p>1b. # fetuses</p>	<p>1c. EGA – LMP</p> <p>_____</p>	<p>1d. EGA – US</p> <p>_____</p>	<p>1e to 1n (1L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR)</p> <p>1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p>1o. (1o.ab.sp, 1o.oth.sp) Results: 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____ 3. <input type="checkbox"/> other (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>
<p>2a. Date of scan</p> <p>___/___/_____</p>	<p>2b. # fetuses</p>	<p>2c. EGA – LMP</p> <p>_____</p>	<p>2d. EGA – US</p> <p>_____</p>	<p>2e to 2n (2L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR)</p> <p>1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p>2o. (2o.ab.sp, 2o.oth.sp) Results: 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____ 3. <input type="checkbox"/> other (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>
<p>3a. Date of scan</p> <p>___/___/_____</p>	<p>3b. # fetuses</p>	<p>3c. EGA – LMP</p> <p>_____</p>	<p>3d. EGA – US</p> <p>_____</p>	<p>3e to 3n (3L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR)</p> <p>1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p>3o. (3o.ab.sp, 3o.oth.sp) Results: 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____ 3. <input type="checkbox"/> other (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>

F. ULTRASOUND REPORTS (continued)					
4a. Date of scan ____ / ____ / ____	4b. # fetuses _____	4c. EGA – LMP _____	4d. EGA – US _____	4e to 4n (4L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR) 1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	4o. (4o.ab.sp, 4o.oth.sp) Results: 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____ 3. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
5a. Date of scan ____ / ____ / ____	5b. # fetuses _____	5c. EGA – LMP _____	5d. EGA – US _____	5e to 5n (5L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR) 1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	5o. (5o.ab.sp, 5o.oth.sp) Results: 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____ 3. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
6a. Date of scan ____ / ____ / ____	6b. # fetuses _____	6c. EGA – LMP _____	6d. EGA – US _____	6e to 6n (6L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR) 1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	6o. (6o.ab.sp, 6o.oth.sp) Results: 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____ 3. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
Comments: _____ _____ _____					

G. SUBSTANCE ABUSE INDEX PREGNANCY <input type="checkbox"/> No information for any item in section					
Drugs/Substance	3 months prior to conception through conception	Trimester 1 Weeks 1 – 12	Trimester 2 Weeks 13 – 26	Trimester 3 Weeks 27 – 40+	Date Stopped
1. Marijuana 1.ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	1.pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	1.t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	1.t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	1.t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	1.ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
2. Cocaine 2.ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	2.pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	2.t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	2.t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	2.t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	2.ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
3. Ecstasy, speed, methamphetamines 3.ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	3.pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	3.t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	3.t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	3.t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	3.ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
4. Other 4.sp (specify): <hr/> 4.ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	4.pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	4.t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	4.t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	4.t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	4.ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
COMMENTS:					

G. SUBSTANCE ABUSE (continued)					
Drugs/Substance	3 months prior to conception	Trimester 1 Weeks 1 – 12	Trimester 2 Weeks 13 – 26	Trimester 3 Weeks 27 – 40+	Date Stopped
<p>5. Tobacco</p> <p>5.ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/></p> <p>IF CHECKED:</p> <p>5.2.notspec Number _____</p> <p>5.3.notspec Unit 1. <input type="checkbox"/>cigs/day 2. <input type="checkbox"/>cigs/week 3. <input type="checkbox"/>packs/day 4. <input type="checkbox"/>packs/week 5. <input type="checkbox"/>other _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>5.1.pc</p> <p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>5.2.pc Number _____</p> <p>5.3.pc Unit 1. <input type="checkbox"/>cigs/day 2. <input type="checkbox"/>cigs/week 3. <input type="checkbox"/>packs/day 4. <input type="checkbox"/>packs/week 5. <input type="checkbox"/>other _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>5.1.t1</p> <p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>5.2.t1 Number _____</p> <p>5.3.t1 Unit 1. <input type="checkbox"/>cigs/day 2. <input type="checkbox"/>cigs/week 3. <input type="checkbox"/>packs/day 4. <input type="checkbox"/>packs/week 5. <input type="checkbox"/>other _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>5.1.t2</p> <p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>5.2.t2 Number _____</p> <p>5.3.t2 Unit 1. <input type="checkbox"/>cigs/day 2. <input type="checkbox"/>cigs/week 3. <input type="checkbox"/>packs/day 4. <input type="checkbox"/>packs/week 5. <input type="checkbox"/>other _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>5.1.t3</p> <p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>5.2.t3 Number _____</p> <p>5.3.t3 Unit 1. <input type="checkbox"/>cigs/day 2. <input type="checkbox"/>cigs/week 3. <input type="checkbox"/>packs/day 4. <input type="checkbox"/>packs/week 5. <input type="checkbox"/>other _____ 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>5.ds</p> <p>___/___/___</p> <p>OR</p> <p>Ongoing Use <input type="checkbox"/></p>
<p>6. Alcohol</p> <p>6.ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/></p> <p>IF CHECKED:</p> <p>6.1.ns</p> <p>1. <input type="checkbox"/> heavy 2. <input type="checkbox"/> moderate 3. <input type="checkbox"/> occasional 4. <input type="checkbox"/> rare/min. 5. <input type="checkbox"/> none 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>OR</p> <p>6.2.ns Drink Number _____</p> <p>6.3.ns Unit 1. <input type="checkbox"/> drinks/day 2. <input type="checkbox"/> drinks/week 3. <input type="checkbox"/> drinks/mth 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>6.1.pc</p> <p>1. <input type="checkbox"/> heavy 2. <input type="checkbox"/> moderate 3. <input type="checkbox"/> occasional 4. <input type="checkbox"/> rare/min. 5. <input type="checkbox"/> none 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>OR</p> <p>6.2.pc Drink Number _____</p> <p>6.3.pc Unit 1. <input type="checkbox"/> drinks/day 2. <input type="checkbox"/> drinks/week 3. <input type="checkbox"/> drinks/mth 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>6.1.t1</p> <p>1. <input type="checkbox"/> heavy 2. <input type="checkbox"/> moderate 3. <input type="checkbox"/> occasional 4. <input type="checkbox"/> rare/min. 5. <input type="checkbox"/> none 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>OR</p> <p>6.2.t1 Drink Number _____</p> <p>6.3.t1 Unit 1. <input type="checkbox"/> drinks/day 2. <input type="checkbox"/> drinks/week 3. <input type="checkbox"/> drinks/mth 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>6.1.t2</p> <p>1. <input type="checkbox"/> heavy 2. <input type="checkbox"/> moderate 3. <input type="checkbox"/> occasional 4. <input type="checkbox"/> rare/min. 5. <input type="checkbox"/> none 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>OR</p> <p>6.2.t2 Drink Number _____</p> <p>6.3.t2 Unit 1. <input type="checkbox"/> drinks/day 2. <input type="checkbox"/> drinks/week 3. <input type="checkbox"/> drinks/mth 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>6.1.t3</p> <p>1. <input type="checkbox"/> heavy 2. <input type="checkbox"/> moderate 3. <input type="checkbox"/> occasional 4. <input type="checkbox"/> rare/min. 5. <input type="checkbox"/> none 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p> <p>OR</p> <p>6.2.t3 Drink Number _____</p> <p>6.3.t3 Unit 1. <input type="checkbox"/> drinks/day 2. <input type="checkbox"/> drinks/week 3. <input type="checkbox"/> drinks/mth 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR</p>	<p>6.ds</p> <p>___/___/___</p> <p>OR</p> <p>Ongoing Use <input type="checkbox"/></p>
<p>Comments:</p>					

H (part 1). MATERNAL INFECTIONS ANYTIME DURING INDEX PREGNANCY

Extra sheet provided in Appendix A if needed

Dx: Use codes from infection list (Appendix D)

If cultures or rapid strep screens were performed, note in section I.

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

No information for any item in section

1a Dx	1b.1 Date diagnosed ___/___/___ OR 1b.ga GA _____ wks OR 1b.tri Trimester _____	1c Duration _____ days	1d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	1e.1 Highest Temp _____ 1e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1f.1 Lowest Temp _____ 1f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
2a Dx	2b.1 Date diagnosed ___/___/___ OR 2b.ga GA _____ wks OR 2b.tri Trimester _____	2c Duration _____ days	2d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	2e.1 Highest Temp _____ 2e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2f.1 Lowest Temp _____ 2f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
3a Dx	3b.1 Date diagnosed ___/___/___ OR 3b.ga GA _____ wks OR 3b.tri Trimester _____	3c Duration _____ days	3d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	3e.1 Highest Temp _____ 3e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3f.1 Lowest Temp _____ 3f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
4a Dx	4b.1 Date diagnosed ___/___/___ OR 4b.ga GA _____ wks OR 4b.tri Trimester _____	4c Duration _____ days	4d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	4e.1 Highest Temp _____ 4e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4f.1 Lowest Temp _____ 4f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR

Comments: Specify any other DX (code=600) as **1a.sp, 2a.sp, 3a.sp, 4a.sp**
Also list other comments.

H (part 2). Fever >37.7 °C or 100 °F			<input type="checkbox"/> No information for any item in section
	5 highest fevers	Date	Time
1.	1a.1 Highest Temp _____ 1a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1b ____ / ____ / ____	1c (military time) ____ : ____
2.	2a.1 Highest Temp _____ 2a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2b ____ / ____ / ____	2c (military time) ____ : ____
3.	3a.1 Highest Temp _____ 3a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3b ____ / ____ / ____	3c (military time) ____ : ____
4.	4a.1 Highest Temp _____ 4a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4b ____ / ____ / ____	4c (military time) ____ : ____
5.	5a.1 Highest Temp _____ 5a.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	5b ____ / ____ / ____	5c (military time) ____ : ____
Comments:			

I. CULTURES/RAPID STREP SCREENS ANYTIME DURING INDEX PREGNANCY (RECORD ALL CULTURES /STREP SCREENS OBTAINED)

Extra sheet provided in Appendix A if needed

Indicate the number of the event from section H or '0' If culture does not correspond to an event in section H.

No information for any item in section

Test/procedure for one or more items in section indicated but no information on dates, results, etc.

Source: 1 = amniotic fluid; 2 = placenta; 3 = cervix; 4 = vagina; 5 = urine; 6 = blood; 7 = sputum; 8=throat; 9 = stool; 10=wound; 11= other (specify); 88 = Illegible 99=Not recorded

1a – 20a REF	1b – 20b Date Cultured	1c–20c 1c.sp- 20c.sp (specify) Source	1d – 20d (1d.6.sp – 20d.6.sp and 1d.9.sp – 20d.9.sp for specify fields) Results	1e – 20e Description (organisms, etc.)
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	

I.CULTURES/RAPID STREP SCREENS (continued)				
Source: 1 = amniotic fluid; 2 = placenta; 3 = cervix; 4 = vagina; 5 = urine; 6 = blood; 7 = sputum; 8=throat; 9 = stool; 10=wound; 11= other (specify); 88 = Illegible 99=Not recorded				
1a – 20a	1b – 20b	1c–20c	1d – 20d	1e – 20e
REF	Date Cultured	1c.sp-20c.sp (specify) Source	(1d.6.sp – 20d.6.sp and 1d.9.sp – 20d.9.sp for specify fields) Results	Description (organisms, etc.)
	___ / ___ / _____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___ / ___ / _____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___ / ___ / _____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___ / ___ / _____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___ / ___ / _____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
Comments:				

J. INJECTIONS/VACCINATIONS DURING INDEX PREGNANCY

Extra sheet provided in Appendix A if needed

No information for any item in section

Injection/Vaccination	Date	Dose	Manufacturer	Product Name	Lot #
1. Rhogam (other RH(D)) Immunoglobulin 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	Date (1.dt1, 1.dt2) 1st ___/___/____ 2nd ___/___/____	Dose (1.ds.1, 1.ds.2) 1st _____ 2nd _____	Manufacturer (1.m.1, 1.m.2) 1st _____ 2nd _____	Product Name (1.p.1, 1.p.2) 1st _____ 2nd _____	Lot # (1.lot.1, 1.lot.2) _____ _____
2. Influenza Vaccine 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2.dt Date ___/___/____	2.m Manufacturer _____		2.lot Lot # _____	
3. Other 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR 3a.sp (specify) _____	3a.dt Date ___/___/____	3a.m Manufacturer _____		3a.lot Lot # _____	
3b.sp Other (specify) _____	3b.dt Date ___/___/____	3b.m Manufacturer _____		3b.lot Lot # _____	
3c.sp Other (specify) _____	3c.dt Date ___/___/____	3c.m Manufacturer _____		3c.lot Lot # _____	
3d.sp Other (specify) _____	3d.dt Date ___/___/____	3d.m Manufacturer _____		3d.lot Lot # _____	
3e.sp Other (specify) _____	3e.dt Date ___/___/____	3e.m Manufacturer _____		3e.lot Lot # _____	
3f.sp Other (specify) _____	3f.dt Date ___/___/____	3f.m Manufacturer _____		3f.lot Lot # _____	

Comments:

K.VAGINAL BLEEDING ANYTIME DURING INDEX PREGNANCY

Extra sheet provided in Appendix A if needed

No information for any item in section

Dx: 1 = Placenta Previa; 2 = Placenta Abruptio; 3 = Trauma; 4 = Effaced/Dilated; 5 = Uterine Rupture; 6 = Implantation Bleeding; 7 = Placenta Accreta; 8 = Other (specify); 88=Illegible, 99=Not Recorded

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

<p>1a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>1a.ga GA ____ wks</p> <p>OR</p> <p>1a.tri Trimester ____</p>	<p>1b. Dx (code)</p> <p>_____</p> <p>If dx=8:</p> <p>1b.sp</p> <p>Other, specify</p>	<p>1c. Duration</p> <p>__ __</p> <p>1c.unit</p> <p>Unit</p> <p>1. <input type="checkbox"/> days</p> <p>2. <input type="checkbox"/> weeks</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>1d. Pain</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>1e. Cramping</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>1f. Medication Given</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>2a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>2a.ga GA ____ wks</p> <p>OR</p> <p>2a.tri Trimester ____</p>	<p>2b. Dx (code)</p> <p>_____</p> <p>If dx=8:</p> <p>2b.sp</p> <p>Other, specify</p>	<p>2c. Duration</p> <p>__ __</p> <p>2c.unit</p> <p>Unit</p> <p>1. <input type="checkbox"/> days</p> <p>2. <input type="checkbox"/> weeks</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>2d. Pain</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>2e. Cramping</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>2f. Medication Given</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>3a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>3a.ga GA ____ wks</p> <p>OR</p> <p>3a.tri Trimester ____</p>	<p>3b. Dx (code)</p> <p>_____</p> <p>If dx=8:</p> <p>3b.sp</p> <p>Other, specify</p>	<p>3c. Duration</p> <p>__ __</p> <p>3c.unit</p> <p>Unit</p> <p>1. <input type="checkbox"/> days</p> <p>2. <input type="checkbox"/> weeks</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>3d. Pain</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>3e. Cramping</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>3f. Medication Given</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>4a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>4a.ga GA ____ wks</p> <p>OR</p> <p>4a.tri Trimester ____</p>	<p>4b. Dx (code)</p> <p>_____</p> <p>If dx=8:</p> <p>4b.sp</p> <p>Other, specify</p>	<p>4c. Duration</p> <p>__ __</p> <p>4c.unit</p> <p>Unit</p> <p>1. <input type="checkbox"/> days</p> <p>2. <input type="checkbox"/> weeks</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>4d. Pain</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>4e. Cramping</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>3. <input type="checkbox"/> Suspect</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>4f. Medication Given</p> <p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> No (stated)</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>

Comments:

L. PRETERM LABOR DURING INDEX PREGNANCY

If “yes” is indicated for medications, please fill out Section Q.

Extra sheet provided in Appendix A if needed

No information for any item in section

<p>1a. Date Reported</p> <p>____/____/____</p> <p>OR</p> <p>1a.ga GA _____ wks</p> <p>OR</p> <p>1a.tri Trimester _____</p>	<p>1b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>1c. and 1c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>1d. and 1d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>2a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>2a.ga GA _____ wks</p> <p>OR</p> <p>2a.tri Trimester _____</p>	<p>2b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>2c. and 2c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>2d. and 2d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>3a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>3a.ga GA _____ wks</p> <p>OR</p> <p>3a.tri Trimester _____</p>	<p>3b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>3c. and 3c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>3d. and 3d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>4a. Date Occurred</p> <p>____/____/____</p> <p>OR</p> <p>4a.ga GA _____ wks</p> <p>OR</p> <p>4a.tri Trimester _____</p>	<p>4b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>4c. and 4c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>4d. and 4d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>

Comments:

M (part 1). MEDICAL CONDITIONS PRECEDING OR DURING INDEX PREGNANCY

Extra sheet provided in Appendix A if needed

Use codes from Medical History List (Appendix E) -- M indicates medical condition

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

No information for any item in section

Precision Code: 1 = Definite diagnosis – ICD or DSM code listed in the provider record; 2 = Specific diagnosis listed by provider in record but no ICD/DSM code listed; 3 = Signs and symptoms of a condition noted by provider in record but diagnosis unclear; 88=Illegible; 99=NR

No.	Condition Code (appendix) 1a.-20a	Precision Code 1b-20b	Time Period Condition Active (Check all that apply)			Date/Age at First Diagnosis 1d.date - 20d.date 1d.age - 20d.age	Medication Given 1e - 20e
			1c.pc - 20c.pc 1c.t3 - 20c.t3 1c.IL - 20c.IL	1c.t1 - 20c.t1 1c.ns - 20c.ns	1c.t2 - 20c.t2, 1c.NR - 20c.NR		
1			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ ____/____/_____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
2			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ ____/____/_____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
3			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ ____/____/_____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
4			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ ____/____/_____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
5			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ ____/____/_____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
6			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ ____/____/_____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR

Comments:

M (part 2). PSYCHIATRIC/BEHAVIORAL/DEVELOPMENTAL CONDITIONS PRECEDING OR DURING INDEX PREGNANCY

Extra sheet provided in Appendix A if needed

Use codes from Medical History List (Appendix E) – PBD indicates psychiatric/ behavioral/ developmental condition

If “yes” is indicated for medications, please fill out Section Q

No information for any item in section

Precision Code: 1 = Definite diagnosis – ICD or DSM code listed in the provider record; 2 = Specific diagnosis listed by provider in record but no ICD/DSM code listed; 3 = Signs and symptoms of a condition noted by provider in record but diagnosis unclear; 88=Illegible; 99=NR

No.	Condition Code (appendix) 1a.-20a	Precision Code 1b-20b	Time Period Condition Active (Check all that apply)			Date/Age at First Diagnosis 1d.date - 20d.date 1d.age - 20d.age	Medication Given 1e - 20e
			1c.pc - 20c.pc 1c.t3 - 20c.t3 1c.IL - 20c.IL	1c.t1 - 20c.t1 1c.ns - 20c.ns 1c.NR - 20c.NR	1c.t2 - 20c.t2		
1			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
2			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
3			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
4			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
5			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
6			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR

Comments

N. PRENATAL PROCEDURES INDEX PREGNANCY

No information for any item in section

Procedure		
1a. Fetal Echocardiogram 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	1b. Date: ___/___/____	1c. Results 1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
2a. External Version 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	2b. # attempts _____	2c. Results 1. <input type="checkbox"/> successful 2. <input type="checkbox"/> unsuccessful 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
3a. Fetal Reduction 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	3b. Date: ___/___/____	3c.1 # of fetuses originally _____ 3c.2 # of fetuses remaining _____
4a. Cerclage 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	4b.1 Date Placed: ___/___/____ 4b.2 Date Removed: ___/___/____	
5a. Fetal Transfusion 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	5b. Date: ___/___/____	5c. Reason:
6a. Fetal Surgery 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	6b. Date: ___/___/____	6c. Type/Description:
7a. Nonstress Test (NST) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	7b. 2 Date: ___/___/____ 7b.1 Date: ___/___/____	7c.1 and 7c.2 Findings: 1) 2)
8a. Contraction Stress Test (CST) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	8b. Date: ___/___/____	8c. Findings:
9a and 9a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	9b Date: ___/___/____	9c Specify findings:
Comments:		

O. OTHER CONDITIONS OR TRAUMA ANYTIME DURING INDEX PREGNANCY

Record only conditions NOT covered in other sections on this form that detail maternal conditions (B, H, K, L, M).

Extra sheet provided in Appendix A if needed

No information for any item in section

Dx: 1 = Decreased Fetal Movement; 2 = Trauma/Injury; 3 = Oligohydramnios; 4 = Polyhydramnios; 5 = IUGR; 6 = Macrosomia; 7 = loss of consciousness; 8 = Spontaneous Reduction; 10 = other, (specify); 88=IL; 99=NR

If “yes” is indicated for medications, please fill out Section Q

1a.date – 10a.date OR 1a.ga – 10a.ga OR 1a.tri – 10a.tri	1b – 10b	1c – 10c	1d – 10d
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __ / __ / ____ OR GA _____ wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR

Comments:

P. HOSPITAL ADMISSIONS/VISITS INDEX PREGNANCY (INPATIENT AND OUTPATIENT)

Do NOT include admissions for delivery. These should be recorded in Section D (#5).

Do NOT include admissions for prenatal testing. These should be recorded in Section N.

For the medical history code(s), use codes from either Appendix D or Appendix E (indicate as d.# or E.#)

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

Extra sheet provided in Appendix A if needed

No information for any item in section

1a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	1b. Hospital/Facility	1c Admit Date ___/___/____	1d GA	1e Discharge Date ___/___/____
1f .1-1f.8 and 1f.sp Procedures (check all that apply) 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	1g.icd1 Dx 1 ICD9	1g.prob1 Dx 1 Problem	1g.mhc1 Dx 1 Medical History Code	1h.1-1h.5 and 1h.sp Treatment: (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded
2a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	2b. Hospital/Facility	2c Admit Date ___/___/____	2d GA	2e Discharge Date ___/___/____
2f .1-2f.8 and 2f.sp Procedures 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	2g.icd1 Dx 1 ICD9	2g.prob1 Dx 1 Problem	2g.mhc1 Dx 1 Medical History Code	2h.1-2h.5 and 2h.sp Treatment (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded
3a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	3b. Hospital/Facility	3c Admit Date ___/___/____	3d GA	3e Discharge Date ___/___/____
3f .1-3f.8 and 3f.sp Procedures 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	3g.icd1 Dx 1 ICD9	3g.prob1 Dx 1 Problem	3g.mhc1 Dx 1 Medical History Code	3h.1-3h.5 and 3h.sp Treatment (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded
3g.icd2 Dx 2 ICD9	3g.prob2 Dx 2 Problem	3g.mhc2 Dx 2 Medical History Code	3g.mhc2 Dx 2 Medical History Code	
3g.icd3 Dx 3 ICD9	3g.prob3 Dx 3 Problem	3g.mhc3 Dx 3 Medical History Code	3g.mhc3 Dx 3 Medical History Code	

P. HOSPITAL ADMISSIONS/VISITS INDEX PREGNANCY (INPATIENT AND OUTPATIENT) (continued)				
4a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	4b. Hospital/Facility	4c. Admit Date ___/___/____	4d. GA	4e. Discharge Date ___/___/____
4f .1-4f.8 and 4f.sp Procedures 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	4g.icd1 Dx 1 ICD9	4g.prob1 Dx 1 Problem	4g.mhc1 Dx 1 Medical History Code	4h.1-4h.5 and 4h.sp Treatment (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded
	4g.icd2 Dx 2 ICD9	4g.prob2 Dx 2 Problem	4g.mhc2 Dx 2 Medical History Code	
	4g.icd3 Dx 3 ICD9	4g.prob3 Dx 3 Problem	4g.mhc3 Dx 3 Medical History Code	
Comments: 				

Q. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES, STEROIDS, HORMONES, AND OTHER MEDICATIONS) GIVEN THREE MONTHS PRIOR TO INDEX PREGNANCY OR DURING INDEX PREGNANCY Extra sheet provided in Appendix A if needed

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

No information for any item in section

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 agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 28 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/___	___/___/___ OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

Q. ALL MEDICATIONS (continued)

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 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 agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 88 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

Q. ALL MEDICATIONS (continued)

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 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 agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 88 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

Q. ALL MEDICATIONS (continued)

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 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 agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 88 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine

1a - 30a Refer	1b - 30b Code	1c - 30c Drug Name	1d - 30d Start Date	1e - 30e 1e.ep - 30e.ep Stop Date	1f - 30f 1f.sp - 30f.sp Dose	1g - 30g 1g.sp - 30g.sp Unit	1h - 30h 1h.sp - 30h.sp Freq
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	8. <input type="checkbox"/> variable	1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 8. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

Study ID Number _____ # continuation sheets for this section (enter only on first page of section)_____

Appendix A

CONTINUATION SHEETS

CONTRIBUTING PROVIDERS Continuation Sheet Data labeling scheme for providers listed on continuation sheets should follow original (see A-E labeling) beginning with F.		
1. Name of Provider/Hospital		
2. Street Address		2. Street Address
3. City	3. City	3. City
ABSTRACTION LOG		
6. Date ____/____/____	6. Date ____/____/____	6. Date ____/____/____
6.1 to 6.8 Time (*use military time)	6.1 to 6.8 Time (*use military time)	6.1 to 6.8 Time (*use military time)
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
9. Date ____/____/____	9. Date ____/____/____	9. Date ____/____/____
9.1 to 9.8 Time (*use military time)	9.1 to 9.8 Time (*use military time)	9.1 to 9.8 Time (*use military time)
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
1. Name of Provider/Hospital		
2. Street Address		2. Street Address
3. City	3. City	3. City
ABSTRACTION LOG		
6. Date ____/____/____	6. Date ____/____/____	6. Date ____/____/____
6.1 to 6.8 Time (*use military time)	6.1 to 6.8 Time (*use military time)	6.1 to 6.8 Time (*use military time)
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
9. Date ____/____/____	9. Date ____/____/____	9. Date ____/____/____
9.1 to 9.8 Time (*use military time)	9.1 to 9.8 Time (*use military time)	9.1 to 9.8 Time (*use military time)
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____
Start ____:____ Stop ____:____	Start ____:____ Stop ____:____	Start ____:____ Stop ____:____

Section A: Maternal Address History Continuation Sheet

(List in reverse chronological order)

Data labeling/numbering scheme for prior addresses listed on continuation sheets should follow original beginning with item #50 for date last known at address

Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Date __/__/____ (last known at this address)	Mother's Street Address		
City	State	Zip Code	
Comments:			

C. PREGNANCY HISTORY UP TO AND INCLUDING INDEX PREGNANCY Continuation Sheet
Data labeling scheme for pregnancies listed on continuation sheets should follow original beginning with Baby #12 (and/or Pregnancy #12 if no multiple births).

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

Pregnancy Number/Baby Number	Outcome	Plurality	Birth Weight	Sex	Type Delivery
Number past pregnancies in reverse chronological order (most recent = 1). If plurality 77, 88 or 99, baby number not needed. For singletons enter 1/1. For pregnancies specified as multiple gestations, list each fetus/infant born separately. E.g. 1/1, 1/2, 1/3, pertain to infants 1, 2, and 3 from pregnancy 1.	1. Live Birth 2. Stillbirth 3. Induced Abortion 4. Spontaneous Abortion 5. Ectopic Pregnancy 6. Molar Pregnancy 7. Maternal Death prior to Birth 8. other specify 88. IL 99. NR	1. Singleton 2. Twin 3. Triplet 4. Quad 5. Quint Etc.... 77. NA (outcomes 3-8) 88. IL 99. NR	Grams preferred, if available Not applicable for outcomes 3-8, record NA Record IL or NR for other missing values as needed.	1. Male 2. Female 3. Ambiguous 77. NA (outcomes 3-8) 88. IL 99. NR	1. Vaginal 2. Primary C-Section 3. Secondary C-Section 4. VBAC 77. NA (outcomes 3-8) 88. IL 99. NR

Prenatal, Delivery, Post Partum Problems/Complications

26. No complications specifically noted	40. Macrosomia
27. Abruptio placentae	41. Placenta previa
28. Birth defect (specify if yes)	42. Postpartum depression
29. Cephalopelvic disproportion	43. Postpartum hemorrhage
30. Chorioamnionitis	44. Pregnancy induced hypertension/ preeclampsia/gestational hypertension
31. Deep vein thrombosis	45. Premature rupture of membranes (PROM)
32. Eclampsia	46. Preterm labor
33. Fetal reduction	47. Pulmonary edema
34. Gestational Diabetes	48. Pulmonary embolus (PE)
35. HELLP	49. Uterine rupture
36. Hyperemesis	50. Vaginal bleeding
37. Infant Death, neonatal (<28 days)	26. Other: specify
38. Infant Death, post-neonatal (28 days – 1 year)	99. Unknown/ Not documented
39. Intrauterine growth restriction/retardation (IUGR)	

10a.1preg – 10a.20preg	10b.1 – 10b.20	10c.1 – 10c.20	10d.1 – 10d.20	10e.1 – 10e.20	10f.1 – 10f.20	10g.1 – 10g.20 OR 10h.1 – 10h.20 (lb) 10i.1 – 10i.20 (oz)	10j.1 – 10j.20	10k.1 – 10k.20	10L..1.1 – 10L.20.28 (Each complication will be a separate y/n variable for each pregnancy+ other specify and NR)
AND 10a.1baby – 10a.20baby			Outcome Month Mm	Outcome Year yyyy	GA Wks	Birth Weight g lbs/oz	Sex	Type Delivery	Complications with mother/infant (record codes; specify detail for “other”)
Preg #	Baby #	Outcome	Plurality						

COMMENTS: Provide indication of preg no/baby no for each comment.

D. MATERNAL MEASUREMENTS INDEX PREGNANCY Continuation Sheet

Data labeling scheme for hospital admissions listed on continuation sheets should follow original beginning with Admission #5a.4.

5. HOSPITAL DELIVERY ADMISSION(S) Record IL or NR for missing information

5a.1 – 5a.x Date <i>mm/dd/yyyy</i>	5b.1 – 5b.x Weeks Gestation <i>(provider's best estimate)</i>	5c.1 – 5d.x 5d.1 – 5d.x Fundal Ht <input type="checkbox"/> cm <input type="checkbox"/> inches <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	5e.1 – 5e.x Fetal Heart Rate	5f.1 – 5f.x Preterm labor <i>signs/ symptoms*</i>	5g.1 – 5g.x 5h.1 – 5h.x Blood Pressure Systolic Diastolic		5i.1 – 5i.x 5j.1 – 5j.x Weight <input type="checkbox"/> Lb <input type="checkbox"/> kg <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all)	5k.1 – 5k.x 5L.1 – 5L.x Urine +albumin +glucose <input type="checkbox"/> IL (all) <input type="checkbox"/> IL (all) <input type="checkbox"/> NR (all) <input type="checkbox"/> NR (all)	
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: Indicate visit no and date.

E. BLOOD TYPE, SCREENING, AND OTHER REPORTS (excluding cultures/rapid strep screens) INDEX PREGNANCY

22. Other Lab Reports (except cultures: to be reported in Section I) Continuation Sheet

Data labeling scheme for other lab reports listed on continuation sheets should follow original beginning with Test # 22a.8.

22a.1-22a.x	22b.1-22b.x	22c.1-22c.x (22c.[1-x].oth.sp)	22d.1-22d.x Normal Lab Range (if available)	22e.1-22e.x
Test Date	Test Name/Description	Results		Comments
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
-- / -- / ----		1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal 3. <input type="checkbox"/> other _____ 4. <input type="checkbox"/> tested, results unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR		
<p>COMMENTS: Indicate item #</p>				

F. PREGNANCY ULTRASOUND REPORTS, INDEX PREGNANCY Continuation Sheet
Data labeling scheme for ultrasound reports listed on continuation sheets should follow original beginning with Ultrasound # 7a.

<p>a. Date of scan</p> <p>___/___/___</p>	<p>b. # fetuses</p>	<p>c. EGA – LMP</p> <p>_____</p>	<p>d. EGA – US</p> <p>_____</p>	<p>e to n (L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR)</p> <p>1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p>o. (o.ab.sp, o.oth.sp) Results:</p> <p>1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____</p> <p>3. <input type="checkbox"/> other (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>
<p>a. Date of scan</p> <p>___/___/___</p>	<p>b. # fetuses</p>	<p>c. EGA – LMP</p> <p>_____</p>	<p>d. EGA – US</p> <p>_____</p>	<p>e to n (L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR)</p> <p>1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p>o. (o.ab.sp, o.oth.sp) Results:</p> <p>1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____</p> <p>3. <input type="checkbox"/> other (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>
<p>a. Date of scan</p> <p>___/___/___</p>	<p>b. # fetuses</p>	<p>c. EGA – LMP</p> <p>_____</p>	<p>d. EGA – US</p> <p>_____</p>	<p>e to n (L.sp) Reason (check all that apply) (Each reason choice will be a separate y/n variable + other specify, IL, NR)</p> <p>1. <input type="checkbox"/> confirm dates 2. <input type="checkbox"/> fetal growth 3. <input type="checkbox"/> placenta 4. <input type="checkbox"/> BPP 5. <input type="checkbox"/> decreased fetal movement 6. <input type="checkbox"/> amniotic fluid volume 7. <input type="checkbox"/> malformation 8. <input type="checkbox"/> other: (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>	<p>o. (o.ab.sp, o.oth.sp) Results:</p> <p>1. <input type="checkbox"/> normal 2. <input type="checkbox"/> abnormal (specify) _____</p> <p>3. <input type="checkbox"/> other (specify) _____</p> <p>88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR</p>

Comments:

G. SUBSTANCE ABUSE Continuation Sheet					
Data labeling scheme for other substances listed on continuation sheet should follow original beginning with # 5.					
Drugs/Substance	3 months prior to conception through conception	Trimester 1 Weeks 1 – 12	Trimester 2 Weeks 13 – 26	Trimester 3 Weeks 27 – 40+	Date Stopped
Other sp (specify): <hr/> ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
Other sp (specify): <hr/> ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
Other sp (specify): <hr/> ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
Other sp (specify): <hr/> ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
Other sp (specify): <hr/> ns Hx of use during/near pregnancy but timing NOT specified? <input type="checkbox"/>	pc 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t1 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t2 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	t3 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 77 <input type="checkbox"/> NA 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	ds ___ / ___ / _____ OR Ongoing Use <input type="checkbox"/>
COMMENTS:					

H (part 1). MATERNAL INFECTIONS ANYTIME DURING INDEX PREGNANCY Continuation Sheet

Dx: Use codes from infection list (Appendix D)

If cultures or rapid strep screens were performed, note in section I.

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

Data labeling scheme for infections listed on continuation sheet should follow original beginning with # 5a.

a Dx	b.1 Date diagnosed ____/____/_____ OR b.ga GA _____ wks OR b.tri Trimester _____	c Duration _____ days	d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	e.1 Highest Temp _____ e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	f.1 Lowest Temp _____ f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
a Dx	b.1 Date diagnosed ____/____/_____ OR b.ga GA _____ wks OR b.tri Trimester _____	c Duration _____ days	d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	e.1 Highest Temp _____ e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	f.1 Lowest Temp _____ f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
a Dx	b.1 Date diagnosed ____/____/_____ OR b.ga GA _____ wks OR b.tri Trimester _____	c Duration _____ days	d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	e.1 Highest Temp _____ e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	f.1 Lowest Temp _____ f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR
a Dx	b.1 Date diagnosed ____/____/_____ OR b.ga GA _____ wks OR b.tri Trimester _____	c Duration _____ days	d Certainty of Dx 1. <input type="checkbox"/> Lab/Test 2. <input type="checkbox"/> Clinical 3. <input type="checkbox"/> Suspect 9. <input type="checkbox"/> unknown	e.1 Highest Temp _____ e.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	f.1 Lowest Temp _____ f.2 Unit 1. <input type="checkbox"/> °C 2. <input type="checkbox"/> °F 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	g Cultures/Rapid Screen done? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	h Meds given? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR

Comments: Specify any other DX (code=600) as **5a.sp, etc**
Also list other comments.

I. CULTURES/RAPID STREP SCREENS ANYTIME DURING INDEX PREGNANCY (RECORD ALL CULTURES /STREP SCREENS OBTAINED) Continuation Sheet

Indicate the number of the event from section H or '0' If culture does not correspond to an event in section H. Data labeling scheme for cultures listed on continuation sheet should follow original beginning with # 11a.

Source: 1 = amniotic fluid; 2 = placenta; 3 = cervix; 4 = vagina; 5 = urine; 6 = blood; 7 = sputum; 8=throat; 9 = stool; 10=wound; 11= other (specify); 88 = Illegible 99=Not recorded

a REF	b Date Cultured	c c.sp (specify) Source	d (d.6.sp and d.9.sp for specify fields) Results	e Description (organisms, etc.)
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	
	___/___/_____		1. <input type="checkbox"/> no growth 2. <input type="checkbox"/> Normal flora 3. <input type="checkbox"/> light growth 4. <input type="checkbox"/> mod-heavy growth 5. <input type="checkbox"/> growth noted, not specified 6. <input type="checkbox"/> urine culture colony count (specify) _____ 7. <input type="checkbox"/> rapid strep screen pos 8. <input type="checkbox"/> rapid strep screen neg 9. <input type="checkbox"/> other (specify) _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR	

Comments:

J. INJECTIONS/VACCINATIONS DURING INDEX PREGNANCY				Continuation Sheet	
Data labeling scheme for injections listed on continuation sheet should follow original beginning with # 3g.sp.					
Injection/Vaccination	dt Date	m Manufacturer	lot Lot #		
Other (specify) _____	____/____/____	_____	_____		
Other (specify) _____	____/____/____	_____	_____		
Other (specify) _____	____/____/____	_____	_____		
Other (specify) _____	____/____/____	_____	_____		
Other (specify) _____	____/____/____	_____	_____		
Comments:					

K.VAGINAL BLEEDING ANYTIME DURING INDEX PREGNANCY Continuation Sheet Data labeling scheme for vaginal bleeding episodes listed on continuation sheet should follow original beginning with # 5a.					
Dx: 1 = Placenta Previa; 2 = Placenta Abruption; 3 = Trauma; 4 = Effaced/Dilated; 5 = Uterine Rupture; 6 = Implantation Bleeding; 7 = Placenta Accreta; 8 = Other (specify); 88=Illegible, 99=Not Recorded If "yes" is indicated for medications, please fill out Section Q					
a. Date Occurred ____ / ____ / ____ OR a.ga GA ____ wks OR a.tri Trimester ____	b. Dx (code) _____ If dx=8: b.sp Other, specify _____	c. Duration ____ ____ c.unit Unit 1. <input type="checkbox"/> days 2. <input type="checkbox"/> weeks 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	d. Pain 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	e. Cramping 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	f. Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR
a. Date Occurred ____ / ____ / ____ OR a.ga GA ____ wks OR a.tri Trimester ____	b. Dx (code) _____ If dx=8: b.sp Other, specify _____	c. Duration ____ ____ c.unit Unit 1. <input type="checkbox"/> days 2. <input type="checkbox"/> weeks 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	d. Pain 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	e. Cramping 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	f. Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR
a. Date Occurred ____ / ____ / ____ OR a.ga GA ____ wks OR a.tri Trimester ____	b. Dx (code) _____ If dx=8: b.sp Other, specify _____	c. Duration ____ ____ c.unit Unit 1. <input type="checkbox"/> days 2. <input type="checkbox"/> weeks 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	d. Pain 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	e. Cramping 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	f. Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR
a. Date Occurred ____ / ____ / ____ OR a.ga GA ____ wks OR a.tri Trimester ____	b. Dx (code) _____ If dx=8: b.sp Other, specify _____	c. Duration ____ ____ c.unit Unit 1. <input type="checkbox"/> days 2. <input type="checkbox"/> weeks 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	d. Pain 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	e. Cramping 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 3. <input type="checkbox"/> Suspect 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR	f. Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No (stated) 88 <input type="checkbox"/> Illegible 99 <input type="checkbox"/> NR
Comments:					

L. PRETERM LABOR INDEX PREGNANCY Continuation Sheet

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

Data labeling scheme for preterm labor episodes listed on continuation sheet should follow original beginning with # 5a.

<p>a. Date Reported</p> <p>___/___/_____</p> <p>OR</p> <p>a.ga GA _____ wks</p> <p>OR</p> <p>a.tri Trimester _____</p>	<p>b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>c. and c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>d. and d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>a. Date Reported</p> <p>___/___/_____</p> <p>OR</p> <p>a.ga GA _____ wks</p> <p>OR</p> <p>a.tri Trimester _____</p>	<p>b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>c. and c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>d. and d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>a. Date Reported</p> <p>___/___/_____</p> <p>OR</p> <p>a.ga GA _____ wks</p> <p>OR</p> <p>a.tri Trimester _____</p>	<p>b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>c. and c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>d. and d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>
<p>a. Date Reported</p> <p>___/___/_____</p> <p>OR</p> <p>a.ga GA _____ wks</p> <p>OR</p> <p>a.tri Trimester _____</p>	<p>b. Onset of s/s per patient</p> <p>1. <input type="checkbox"/> no s/s (stated)</p> <p>2. <input type="checkbox"/> < 12 h</p> <p>3. <input type="checkbox"/> 12 – 24 h</p> <p>4. <input type="checkbox"/> > 24 h</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>c. and c.sp Signs/symptoms</p> <p>1. <input type="checkbox"/> uterine contractions</p> <p>2. <input type="checkbox"/> cramping (per patient)</p> <p>3. <input type="checkbox"/> cervical change</p> <p>4. <input type="checkbox"/> PROM</p> <p>5. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>	<p>d. and d.sp Treatments</p> <p>1. <input type="checkbox"/> meds (fill out section Q)</p> <p>2. <input type="checkbox"/> bed rest</p> <p>3. <input type="checkbox"/> IV Hydration</p> <p>4. <input type="checkbox"/> other, specify _____</p> <p>88 <input type="checkbox"/> Illegible</p> <p>99 <input type="checkbox"/> NR</p>

Comments:

M (part 1). MEDICAL CONDITIONS PRECEDING OR DURING INDEX PREGNANCY

Continuation Sheet

Use codes from Medical History List (Appendix E) -- M indicates medical condition

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

Data labeling scheme for medical conditions listed on continuation sheet should follow original beginning with # 7.

Precision Code: 1 = Definite diagnosis – ICD or DSM code listed in the prenatal record; 2 = Specific diagnosis listed by provider in prenatal record but no ICD/DSM code listed; 3 = Signs and symptoms of a condition noted in prenatal record but diagnosis unclear; 88=Illegible; 99=NR

No.	Condition Code (appendix) 1a.-20a	Precision Code 1b.-20b	Time Period Condition Active (Check all that apply)			Date/Age at First Diagnosis 1d.date - 20d.date 1d.age - 20d.age	Medication Given 1e - 20e
			1c.pc - 20c.pc 1c.t3 - 20c.t3 1c.IL - 20c.IL	1c.t1 - 20c.t1 1c.ns - 20c.ns 1c.NR - 20c.NR	1c.t2 - 20c.t2		
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: _____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR

Comments:

M (part 2). PSYCHIATRIC/BEHAVIORAL/DEVELOPMENTAL CONDITIONS PRECEDING OR DURING INDEX PREGNANCY

Continuation Sheet

Study ID Number _____ # continuation sheets for this section (enter only on first page of section)

Use codes from Medical History List (Appendix E) – PBD indicates psychiatric/ behavioral/ developmental condition

If “yes” is indicated for medications, please fill out Section Q

Data labeling scheme for PBD conditions listed on continuation sheet should follow original beginning with # 7.

Precision Code: 1 = Definite diagnosis – ICD or DSM code listed in the prenatal record; 2 = Specific diagnosis listed by provider in prenatal record but no ICD/DSM code listed; 3 = Signs and symptoms of a condition noted in prenatal record but diagnosis unclear; 88=Illegible; 99=NR

No.	Condition Code (appendix) 1a.-20a	Precision Code 1b-20b	Time Period Condition Active (Check all that apply)			Date/Age at First Diagnosis 1d.date - 20d.date 1d.age - 20d.age	Medication Given 1e - 20e
			1c.pc - 20c.pc 1c.t3 - 20c.t3 1c.IL - 20c.IL	1c.t1 - 20c.t1 1c.ns - 20c.ns	1c.t2 - 20c.t2, 1c.NR - 20c.NR		
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
			1. <input type="checkbox"/> Active before index pregnancy 2. <input type="checkbox"/> Active during 1 st trimester (1-13 weeks GA) 3. <input type="checkbox"/> Active during 2 nd trimester (14-26 weeks GA) 4. <input type="checkbox"/> Active during 3 rd trimester (27-40+ weeks GA) 5. <input type="checkbox"/> Active during index pregnancy, trimester unknown 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR			Date: _____ OR Age: ____	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Comments							

N. PRENATAL PROCEDURES INDEX PREGNANCY Continuation Sheet Data labeling scheme for other prenatal procedures listed on continuation sheet should follow original beginning with # 10.		
Procedure		
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
a and a.sp Other, 1 <input type="checkbox"/> Yes: specify _____ 2 <input type="checkbox"/> No 88 <input type="checkbox"/> IL 99 <input type="checkbox"/> NR	b Date: __ / __ / ____	c Specify findings:
Comments:		

O. OTHER CONDITIONS OR TRAUMA ANYTIME DURING INDEX PREGNANCY Continuation Sheet
Record only conditions NOT covered in other sections on this form that detail maternal conditions (B, H, K, L, M).
Data labeling scheme for other conditions/trauma listed on continuation sheet should follow original beginning with # 10.

Dx: 1 = Decreased Fetal Movement; 2 = Trauma/Injury; 3 = Oligohydramnios; 4 = Polyhydramnios; 5 = IUGR; 6 = Macrosomia; 7 = loss of consciousness; 8 = Spontaneous Reduction; 10 = other, (specify); 88=IL; 99=NR
If "yes" is indicated for medications, please fill out Section Q

a.date OR a.ga OR a.tri	b	c	d
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR
Date Reported __/__/____ OR GA _____wks OR Trimester ____	Dx	Description	Medication Given 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR

Comments:

P. HOSPITAL ADMISSIONS/VISITS INDEX PREGNANCY (INPATIENT AND OUTPATIENT)

Continuation Sheet

Do NOT include admissions for delivery. These should be recorded in Section D (#5).

Do NOT include admissions for prenatal testing. These should be recorded in Section N.

For the medical history code(s), use codes from either Appendix D or Appendix E (indicate as d.# or E.#)

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

Data labeling scheme for hospital admissions/visits listed on continuation sheet should follow original beginning with # 5a.

<p>a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>b. Hospital/Facility</p>	<p>c Admit Date ___/___/_____</p>	<p>d GA</p>	<p>e Discharge Date ___/___/_____</p>
<p>f.1-f.8 and f.sp Procedures (check all that apply) 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>g.icd1 Dx 1 ICD9</p>	<p>g.prob1 Dx 1 Problem</p>	<p>g.mhc1 Dx 1 Medical History Code</p>	<p>h.1-h.5 and h.sp Treatment: (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded</p>
	<p>g.icd2 Dx 2 ICD9</p>	<p>g.prob2 Dx 2 Problem</p>	<p>g.mhc2 Dx 2 Medical History Code</p>	
	<p>g.icd3 Dx 3 ICD9</p>	<p>g.prob3 Dx 3 Problem</p>	<p>g.mhc3 Dx 3 Medical History Code</p>	
<p>a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>b. Hospital/Facility</p>	<p>c Admit Date ___/___/_____</p>	<p>d GA</p>	<p>e Discharge Date ___/___/_____</p>
<p>f.1-f.8 and f.sp Procedures (check all that apply) 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>g.icd1 Dx 1 ICD9</p>	<p>g.prob1 Dx 1 Problem</p>	<p>g.mhc1 Dx 1 Medical History Code</p>	<p>h.1-h.5 and h.sp Treatment: (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded</p>
	<p>g.icd2 Dx 2 ICD9</p>	<p>g.prob2 Dx 2 Problem</p>	<p>g.mhc2 Dx 2 Medical History Code</p>	
	<p>g.icd3 Dx 3 ICD9</p>	<p>g.prob3 Dx 3 Problem</p>	<p>g.mhc3 Dx 3 Medical History Code</p>	
<p>a. Treated in/as 1. <input type="checkbox"/> ER 2. <input type="checkbox"/> outpatient 3. <input type="checkbox"/> inpatient 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>b. Hospital/Facility</p>	<p>c Admit Date ___/___/_____</p>	<p>d GA</p>	<p>e Discharge Date ___/___/_____</p>
<p>f.1-f.8 and f.sp Procedures (check all that apply) 1. <input type="checkbox"/> x-rays, including dental 2. <input type="checkbox"/> mammograms 3. <input type="checkbox"/> CT/CAT scans 4. <input type="checkbox"/> MRI/Magnetic Resonance 5. <input type="checkbox"/> Radionuclide study or scan 6. <input type="checkbox"/> radiation treatments or scan 7. <input type="checkbox"/> other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> NR</p>	<p>g.icd1 Dx 1 ICD9</p>	<p>g.prob1 Dx 1 Problem</p>	<p>g.mhc1 Dx 1 Medical History Code</p>	<p>h.1-h.5 and h.sp Treatment: (all that apply) 1. <input type="checkbox"/> Surgery 2. <input type="checkbox"/> Meds 3. <input type="checkbox"/> Other, specify _____ 88. <input type="checkbox"/> IL 99. <input type="checkbox"/> none recorded</p>
	<p>g.icd2 Dx 2 ICD9</p>	<p>g.prob2 Dx 2 Problem</p>	<p>g.mhc2 Dx 2 Medical History Code</p>	
	<p>g.icd3 Dx 3 ICD9</p>	<p>g.prob3 Dx 3 Problem</p>	<p>g.mhc3 Dx 3 Medical History Code</p>	

Comments:

Q. ALL MEDICATIONS (INCLUDING ALL ANTI-INFECTIVES, STEROIDS, HORMONES, AND OTHER Q. MEDICATIONS) GIVEN THREE MONTHS PRIOR TO INDEX PREGNANCY OR DURING INDEX PREGNANCY Continuation Sheet

Indicate the number of the event from the corresponding section.

If the medication does not correspond to a section above, enter '0'.

Data labeling scheme for medications listed on continuation sheet should follow original beginning with # 17a.

Drug Codes: 9 = Steroids (lung maturity); 10 = antidiabetes; 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 agents; 23 = ergotrate; 24 = antidepressants; 25 = prenatal vitamins; 26 = asthma; 27 = preterm labor prevention; 28 = other (specify); 99 = unknown

Exclusions: laxatives, enemas, disinfectants, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, Tylenol, methergine

a Refer	b Code	c Drug Name	d Start Date	e, e.ep Stop Date	f f.sp Dose	g g.sp Unit	h h.sp Freq
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 6. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 6. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 6. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR
			___/___/_____	___/___/_____	OR <input type="checkbox"/> Entire pregnancy or ongoing	8. <input type="checkbox"/> variable 1. <input type="checkbox"/> gm 2. <input type="checkbox"/> mg 3. <input type="checkbox"/> mcg 4. <input type="checkbox"/> mU 5. <input type="checkbox"/> cc/ml 6. <input type="checkbox"/> other _____ 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR	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. <input type="checkbox"/> Every ___ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 77. <input type="checkbox"/> NA 88. <input type="checkbox"/> Illegible 99. <input type="checkbox"/> NR

APPENDIX B. ART TREATMENT DETAIL, INDEX PREGNANCY

**Short Form: Use to record information from PRENATAL CARE RECORD on ART treatments
If ART PROVIDER RECORD available complete APPENDIX C.**

- Appendix C completed instead of Appendix B
 ART treatment was used for index pregnancy, but no information provided for any item in Appendix B (or Appendix C).

1. Date ART treatment cycle started (start of ovulation medication) (mm/dd/yyyy) __/__/____

2. Date oocytes retrieved from mother/woman serving as egg donor (mm/dd/yyyy) __/__/____

3. Date embryos transferred (mm/dd/yyyy) __/__/____

4a-4e Oocyte embryo source (CHECK ALL THAT APPLY OR 88 or 99):

1. PATIENT – used own oocytes embryos
 2. DONOR OOCYTE -- used oocytes from donor
 3. DONOR EMBRYO -- used embryos donated from another couple’s ART
 88. Illegible
 99. Not recorded

5a-5d Oocyte embryo state (CHECK ALL THAT APPLY OR 88 or 99):

1. FRESH – transferred fresh oocytes/embryos retrieved during treatment cycle
 2. FROZEN – transferred thawed embryos from a previous treatment cycle
 88. Illegible
 99. Not recorded

6a-6f Transfer Method (CHECK ALL THAT APPLY OR 88 or 99):

1. IVF: Transcervical
 2. GIFT: Gametes to tubes
 3. ZIFT: Zygotes to tubes
 4. TET: tubal embryo transfer
 88. Illegible
 99. Not recorded

7. Gestational carrier (surrogate) used? 1. Yes 2. No 88. Illegible 99. Not recorded

8. Intracytoplasmic sperm injection (ICSI) performed on oocytes:

1. Yes 2. No 88. Illegible 99. Not recorded

9. Pre-implantation genetic diagnosis (PGD) performed on embryos

1. Yes 2. No 88. Illegible 99. Not recorded

9.sp If Yes, record any comments on type/reason for PGD _____

COMMENTS

APPENDIX C. ART TREATMENT DETAIL, INDEX PREGNANCY
Long Form: Use to record treatment information from ART PROVIDER RECORD.
If ART PROVIDER RECORD not available, but some information in PRENATAL CARE RECORD complete APPENDIX B and leave APPENDIX C blank.

<p>Historical data:</p> <p>1a. Number prior fresh ART cycles _____</p> <p>1b. Number prior frozen ART cycles _____</p> <p>1c. Number prior ART cycles (unknown fresh or frozen) _____</p>	<p>2a-2L and 2i.sp Reason for ART (select all that apply)</p> <table style="width:100%;"> <tr> <td>1. <input type="checkbox"/> Male infertility</td> <td>7. <input type="checkbox"/> Diminished ovarian reserve</td> </tr> <tr> <td>2. <input type="checkbox"/> History of endometriosis</td> <td>8. <input type="checkbox"/> Uterine factor</td> </tr> <tr> <td>3. <input type="checkbox"/> Tubal ligation (not reversed)</td> <td>9. <input type="checkbox"/> Other reason _____</td> </tr> <tr> <td>4. <input type="checkbox"/> Tubal disease (hydrosalpinx)</td> <td>10. <input type="checkbox"/> Unexplained infertility</td> </tr> <tr> <td>5. <input type="checkbox"/> Other tubal disease (not hydrosalpinx)</td> <td>88. <input type="checkbox"/> Illegible</td> </tr> <tr> <td>6. <input type="checkbox"/> Ovulatory disorder/PCO</td> <td>99. <input type="checkbox"/> Not recorded</td> </tr> </table>	1. <input type="checkbox"/> Male infertility	7. <input type="checkbox"/> Diminished ovarian reserve	2. <input type="checkbox"/> History of endometriosis	8. <input type="checkbox"/> Uterine factor	3. <input type="checkbox"/> Tubal ligation (not reversed)	9. <input type="checkbox"/> Other reason _____	4. <input type="checkbox"/> Tubal disease (hydrosalpinx)	10. <input type="checkbox"/> Unexplained infertility	5. <input type="checkbox"/> Other tubal disease (not hydrosalpinx)	88. <input type="checkbox"/> Illegible	6. <input type="checkbox"/> Ovulatory disorder/PCO	99. <input type="checkbox"/> Not recorded
1. <input type="checkbox"/> Male infertility	7. <input type="checkbox"/> Diminished ovarian reserve												
2. <input type="checkbox"/> History of endometriosis	8. <input type="checkbox"/> Uterine factor												
3. <input type="checkbox"/> Tubal ligation (not reversed)	9. <input type="checkbox"/> Other reason _____												
4. <input type="checkbox"/> Tubal disease (hydrosalpinx)	10. <input type="checkbox"/> Unexplained infertility												
5. <input type="checkbox"/> Other tubal disease (not hydrosalpinx)	88. <input type="checkbox"/> Illegible												
6. <input type="checkbox"/> Ovulatory disorder/PCO	99. <input type="checkbox"/> Not recorded												

3. Date ART treatment cycle started (start of ovulation medication) (mm/dd/yyyy) ___/___/_____

4a – 4e. Oocyte embryo source (CHECK ALL THAT APPLY OR 88 or 99):

1. PATIENT – used own oocytes embryos
 2. DONOR OOCYTE -- used oocytes from donor
 3. DONOR EMBRYO -- used embryos donated from another couple’s ART
 88. Illegible
 99. Not recorded

5a – 5d. Oocyte embryo state (CHECK ALL THAT APPLY OR 88 or 99):

1. FRESH – transferred fresh oocytes/embryos retrieved during treatment cycle
 2. FROZEN – transferred thawed embryos from a previous treatment cycle
 88. Illegible
 99. Not recorded

6a – 6f. Transfer Method (CHECK ALL THAT APPLY OR 88 or 99):

1. IVF: Transcervical
 2. GIFT: Gametes to tubes
 3. ZIFT: Zygotes to tubes
 4. TET: tubal embryo transfer
 88. Illegible
 99. Not recorded

7. Gestational carrier (surrogate) used? 1. Yes 2. No 88. Illegible 99. Not recorded

Patient Medication:

8. Patient medicated to stimulate follicular development?
 1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

8.cl. Medications containing clomiphene? 1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

8.cl.dose If yes, Clomiphene dosage (total mgs): _____

8.fsh. Medications containing FSH? 1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

8.fsh .dose If Yes, FSH Medication dosage (total IUs): _____

8.gnrh GnRH Protocol (select only one, if applicable)

1. <input type="checkbox"/> GnRH Agonist Suppression	77. <input type="checkbox"/> Not Applicable
2. <input type="checkbox"/> GnRH Agonist Flare	88. <input type="checkbox"/> Illegible
3. <input type="checkbox"/> GnRH Antagonist Suppression	99. <input type="checkbox"/> Not recorded

APPENDIX C. ART TREATMENT DETAIL, INDEX PREGNANCY

Long Form: Use to record treatment information from ART PROVIDER RECORD (Continued)

Donor Medication:

9. Donor medicated to stimulate follicular development?

1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

9.cl Donor medications containing clomiphene?

1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

9.cl .dose If yes, Donor Clomiphene dosage (total mgs): _____

9.fsh Donor Medications containing FSH?

1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

9.fsh.dose If Yes, Donor FSH Medication dosage (total IUs): _____

9.gnrh Donor GnRH Protocol (select only one, if applicable)

1. GnRH Agonist Suppression 77. Not Applicable
 2. GnRH Agonist Flare 88. Illegible
 3. GnRH Antagonist Suppression 99. Not recorded

10a-10k and 10h.sp Complications related to ART (Select all that apply)

- | | | |
|---|---|--|
| 1. <input type="checkbox"/> Infection | 5. <input type="checkbox"/> Medication side effect | 9. <input type="checkbox"/> None (specified as none) |
| 2. <input type="checkbox"/> Hemorrhage | 6. <input type="checkbox"/> Anesthetic complication | 88. <input type="checkbox"/> Illegible |
| 3. <input type="checkbox"/> Moderate ovarian hyperstimulation | 7. <input type="checkbox"/> Psychological stress | 99. <input type="checkbox"/> Not recorded |
| 4. <input type="checkbox"/> Severe ovarian hyperstimulation | 8. <input type="checkbox"/> Other _____ | |

10.hosp Hospitalization related to a complication above?

1. Yes 2. No 77. Not applicable 88. Illegible 99. Not recorded

Patient retrieval data:

11a Date *patient* oocyte retrieval performed mm/dd/yyyy ___-___-_____

11b Number of oocytes retrieved _____

Donor retrieval data:

12a Date *donor* oocyte retrieval performed mm/dd/yyyy ___-___-_____

12b Number of donor oocytes retrieved _____

13. Source of semen used for fertilization:

1. partner 4. unknown because embryos thawed from a previous cycle
 2. donor 88. Illegible
 3. mixed 99. Not recorded

Manipulation techniques:

14a. Intracytoplasmic sperm injection (ICSI) performed on oocytes

1. Yes 2. No 88. Illegible 99. Not recorded

14b. Assisted hatching performed on embryos 1. Yes 2. No 88. Illegible 99. Not recorded

14c.1 Pre-implantation genetic diagnosis (PGD) performed on embryos

1. Yes 2. No 3. Unknown because embryos thawed from previous cycle
 88. Illegible 99. Not recorded

14c.2 If Yes, **PGD Reason:**

- | | |
|--|---|
| 1. <input type="checkbox"/> prevention genetic disorders | 88. <input type="checkbox"/> Illegible |
| 2. <input type="checkbox"/> screening for aneuploidy | 99. <input type="checkbox"/> Not recorded |
| 3. <input type="checkbox"/> Other _____ | |

APPENDIX C. ART TREATMENT DETAIL, INDEX PREGNANCY

Long Form: Use to record treatment information from ART PROVIDER RECORD (Continued)

Embryo Transfer:

15a. Date of embryo transfer: mm/dd/yyyy __ - __ - ____

15b. Number of FRESH embryos transferred to uterus _____

15c. Number of THAWED embryos transferred to uterus _____

15d. Number of FRESH embryos transferred to FALLOPIAN TUBES _____

15e. Number of THAWED embryos transferred to FALLOPIAN TUBES _____

15f. Number of OOCYTES transferred to FALLOPIAN TUBES _____

Pregnancy ultrasound:

16a. Once pregnant was ultrasound performed? 1. Yes 2. No 88. Illegible 99. Not recorded

16b. Date ultrasound with max number fetal hearts observed: mm/dd/yyyy __ - __ - ____

16c. Maximum fetal hearts on ultrasound prior to reduction,
(record 0 if ultrasound performed but no hearts observed) _____

COMMENTS

APPENDIX D. DIAGNOSTIC CODES, SECTION H – INFECTIONS			
Code	Infection	Code	Infection
501	Bacteremia/sepsis	528	Myocarditis
502	Chicken pox / Varicella (other than Shingles)	512	Parvovirus / Fifth disease
503	Chlamydia	529	Periodontitis
504	Chorioamnionitis	530	Pertussis / Whooping Cough
505	Congenital or intrauterine viral infections (TORCHS)	531	Pneumonia, bacterial
506	Cytomegalovirus	532	Pneumonia, viral
507	Diphtheria	533	Pneumonia, NOS
508	Ear Infection	534	Respiratory infection, NOS (includes, sinuses, throat, bronchi, and lungs) (see separate headings for ear infection, pneumonia, tonsillitis, tuberculosis, and specific viral infections such as influenza, RSV, etc.)
509	Encephalitis	535	Respiratory Syncytial Virus (RSV)
510	Endocarditis	536	Rheumatic fever
511	Eye Infection	513	Rubella/ German Measles
512	Fifth disease / Parvovirus	501	Sepsis/bacteremia
513	German Measles / Rubella	537	Sepsis, Presumed
514	Hepatitis A	538	Shingles
515	Hepatitis B	539	Skin Infection, NOS
516	Hepatitis C	540	Syphilis
517	Hepatitis (type Unknown)	541	Tetanus
518	Herpes Virus	542	Tonsillitis (includes enlargement of tonsils or adnoids at least one month)
519	Human Immunodeficiency Virus (HIV)	543	Toxoplasmosis
520	Influenza	544	Tuberculosis
521	Lyme Disease	545	Urinary tract infection (includes bladder infection and pyelonephritis)
513	Measles, German / Rubella	546	Vaginal Infection/Vaginitis/Vaginosis
522	Measles NOS	502	Varicella / Chicken pox (other than Shingles)
523	Meningitis, bacterial	530	Whooping Cough / Pertussis
524	Meningitis, viral	547	Wound Infection
525	Meningitis, NOS	600	Other (specify)
526	Mononucleosis	IL	Illegible
527	Mumps	NR	Not recorded

Study ID Number _____ # continuation sheets for this section (enter only on first page of section) _____
APPENDIX E MEDICAL (M) AND PSYCHIATRIC/BEHAVIORAL/DEVELOPMENTAL (PBD) CODE LIST

(Separate attachment)