OMB#: 0925-0584
Exp. xx/xx/xxxx

HCHS/SOL Visit 2- Pregnancy Complications History

ID NUMBER:									FORM CODE: PCE VERSION: 1, 6/3/2014	Contact Occasion	0	2	SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response. Complete one form for each pregnancy of 6 or more months in duration. Use the CDART Notelog window to code 'Don't know/refused, Missing, etc.' for those questions that do not list these as an option.

A. PREGNANCY HISTORY QUESTIONS

Now, we would like to ask you some more detailed questions about your pregnancies that lasted more than six months and occurred after SOL Visit 1 on [DATE]

BEGIN WITH THE FIRST PREGNANCY SINCE VISIT 1 *on* [DATE]

1. Tell us about your first through [N]th pregnancy lasting six months or longer
   a. Pregnancy Number ☐
   b. Year pregnancy ended ☐☐☐☐
   c. Did you have hypertension or high blood pressure? (*Told you your pressure was increased)*
      No 0 ☐
      Yes 1 ☐
      Unsure 9 ☐

      c1. Did you have high blood pressure or hypertension before this pregnancy?
         No 0 ☐
         Yes 1 ☐
         Unsure 9 ☐
   d. Did you have Preeclampsia or toxemia? (*Told you your blood pressure was increased and had protein in the urine? Did they tell you there was protein in the urine?)*
      No 0 ☐
      Yes 1 ☐
   e. Did you have eclampsia? (convulsions or seizures*)*
      No 0 ☐
      Yes 1 ☐
   f. Did you have diabetes? (*Did they tell you that your sugar was too high?)*
      No 0 ☐
      Yes 1 ☐

f1. Did you take medication for your blood sugar during this pregnancy?

No	0 ☐
Yes, pills only	1 ☐
Yes, insulin only	2 ☐
Yes, pills and insulin	3 ☐
Unsure/don't know	9 ☐

f2. Did you have diabetes before this pregnancy?

No	0 ☐
Yes	1 ☐
Unsure	9 ☐

g. In the three months before your pregnancy, or before you realized you were pregnant, did you smoke daily, occasionally, or not at all?

Not at all	0 ☐
Occasionally	1 ☐
Daily	2 ☐

h. During the last 3 months of your pregnancy did you smoke daily, occasionally, or not at all?

Not at all	0 ☐
Occasionally	1 ☐
Daily	2 ☐

2. What was the date of this birth? ☐☐/☐☐/☐☐☐☐
MM / DD / YYYY

3. How many months or weeks had you been pregnant when (the baby was born/the [multi] were born/the pregnancy ended)?

number ☐☐ OF

Month	1 ☐	Go to Question 4
Weeks	2 ☐	Go to Question 4

a. If unknown duration, ask: Preterm delivery is one that occurs at 36 weeks or earlier in pregnancy. As far as you know, did you have a preterm delivery?

No	0 ☐
Yes	1 ☐
Unsure	9 ☐

4. How did this pregnancy end (check one)?

Vaginal birth	1 ☐
C-section	2 ☐
Stillbirth	3 ☐

5. Where did you give birth (check one)?

In a hospital 1

In a birthing center 2 ☐

In your home or home other place 3 Go to Question 6

If this birth happened in a hospital or birthing center, ask:

a. What was the name of the facility where you gave birth?_____

b. What was the address of the facility? _____

c. Just to be clear, under what name is this in the records?

5c1. First name: _____

5c2. Second name: _____

5c3. Last Name: _____

5c4. Maternal Last Name: _____

6. How much weight did you gain during this pregnancy?

☐☐ lbs 1 ☐

kgs 2 ☐

7. How many babies were born during this birth?

☐ Babies → For each baby born in this birth, complete row of table 8

Table 8

#	Baby	Sex (a)	Weight in pounds and ounces or grams (b)	If uncertain (c)
8.	1	☐ M ☐ F	☐☐ lbs ☐☐ oz OR ☐☐☐☐ g	☐ Less than 5 ½ lbs (2500g)? ☐ Between 5 ½ and 9 lbs? ☐ More than 9 lbs (4000g)?
9.	2	☐ M ☐ F	☐☐ lbs ☐☐ oz OR ☐☐☐☐ g	☐ Less than 5 ½ lbs (2500g)? ☐ Between 5 ½ and 9 lbs? ☐ More than 9 lbs (4000g)?
10.	3	☐ M ☐ F	☐☐ lbs ☐☐ oz OR ☐☐☐☐ g	☐ Less than 5 ½ lbs (2500g)? ☐ Between 5 ½ and 9 lbs? ☐ More than 9 lbs (4000g)?
11.	4	☐ M ☐ F	☐☐ lbs ☐☐ oz OR ☐☐☐☐ g	☐ Less than 5 ½ lbs (2500g)? ☐ Between 5 ½ and 9 lbs? ☐ More than 9 lbs (4000g)?

12. **IF LIVEBIRTH**, How old was this baby / these babies when you completely stopped breastfeeding or pumping milk? **[Enter 00 if never breastfed]**

☐☐ WEEKS (if younger than 4 weeks)

OR ☐☐ MONTHS

☐ I am still breastfeeding Go To Question

13. If breastfeeding has stopped, ask: Did you breastfeed as long as you wanted to?

No 0 ☐

Yes 1 ☐

14. If breastfed, ask: How old was this baby/these babies when first fed formula or solid foods?

☐☐ DAYS (if younger than 2 weeks)

OR ☐☐ WEEKS

☐ This baby has not been fed formula or solid foods