

**National ART Surveillance System
NASS 2.0
(Proposed for 2016)**

DRAFT

INITIAL REPORTING: PATIENT PROFILE (PROSPECTIVE)	
Quex ID	LEAD QUESTION
1	Date of cycle reporting (mm/dd/yyyy): _ _ - _ _ - _ _ _ _
2	NASS Patient ID: _ _ _ _ - _ _ _ _ - _ _
3	Patient Optional Identifiers Optional Identifier 1 _ _ _ _ _ _ _ _ maximum 7 digits or characters Optional Identifier 2 _ _ _ _ _ _ _ _ maximum 7 digits or characters
4	Patient Date of Birth (mm/dd/yyyy): _ _ - _ _ - _ _ _ _
5	Sex of patient: <input type="radio"/> Male <input type="radio"/> Female
6	Cycle Start Date _ _ - _ _ - _ _ _ _
RESIDENCY	
7	At the start of the cycle, is patient residency primarily in U.S.? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused
7A	U.S. state of primary residence: <input type="text"/> City of primary residence <input type="text"/> U.S. zip code at primary residence _ _ _ _ _ OR Country of primary residence: <input type="text"/>
INTENT	
8	Intended type of ART? Select all that apply: <input type="checkbox"/> IVF: Transcervical <input type="checkbox"/> GIFT: Gametes to tubes <input type="checkbox"/> ZIFT: Zygotes to tubes or TET: tubal embryo transfer <input type="checkbox"/> Oocyte or embryo banking
9	If cycle is for banking only, specify banking type (select all that apply): <input type="checkbox"/> Embryo banking <input type="checkbox"/> Autologous oocyte banking <input type="checkbox"/> Donor oocyte banking
9A	Indicate anticipated duration of oocyte banking SKIP IF EMBRYO BANKING ONLY <input type="checkbox"/> Short term (<12 months) <input type="checkbox"/> Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments <input type="checkbox"/> Long term (≥12 months) banking for other reasons
9B	Indicate anticipated duration of embryo banking SKIP IF OOCYTE BANKING ONLY <input type="checkbox"/> Short term (<12 months) <input type="checkbox"/> Delay of transfer to obtain genetic information <input type="checkbox"/> Delay of transfer for other reasons <input type="checkbox"/> Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments <input type="checkbox"/> Long term (≥12 months) banking for other reasons
10	Intended embryo source (select all that apply): <input type="checkbox"/> Patient embryos <input type="checkbox"/> Donor embryos [IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #12]
10A	If intent is to use FRESH EMBRYOS, specify intended oocyte source. Select all that apply: <input type="checkbox"/> Patient oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes <input type="checkbox"/> Donor oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes If intent is to use FROZEN EMBRYOS, specify intended oocyte source. Select all that apply:

	<input type="checkbox"/> Patient oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes <input type="checkbox"/> Donor oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes <input type="checkbox"/> Unknown (select only if oocyte source is unknown)
11	Specify intended sperm source. Select all that apply. [SKIP IF DONOR EMBRYO IS INTENDED SOURCE] <input type="checkbox"/> Partner <input type="checkbox"/> Donor <input type="checkbox"/> Patient, if male <input type="checkbox"/> Unknown (select only if <u>all</u> sperm sources unknown for frozen)
12	Pregnancy carrier <input type="checkbox"/> Patient <input type="checkbox"/> Gestational carrier <input type="checkbox"/> None (oocyte or embryo banking cycle only)

CYCLE INFORMATION (NOT PROSPECTIVE FROM HERE FORWARD)

Quex ID	LEAD QUESTION
13	Type of ART performed? Select all that apply: <input type="checkbox"/> IVF: Transcervical <input type="checkbox"/> GIFT: Gametes to tubes <input type="checkbox"/> ZIFT: Zygotes to tubes or TET: tubal embryo transfer <input type="checkbox"/> Oocyte or embryo banking
14	Embryo source (select all that apply): <input type="checkbox"/> Patient embryos <input type="checkbox"/> Donor embryos [IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #15]
14A	If FRESH EMBRYOS were used, specify intended oocyte source. Select all that apply: <input type="checkbox"/> Patient oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes <input type="checkbox"/> Donor oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes If FROZEN EMBRYOS were used, specify intended oocyte source. Select all that apply: <input type="checkbox"/> Patient oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes <input type="checkbox"/> Donor oocytes <input type="checkbox"/> Fresh oocytes <input type="checkbox"/> Frozen oocytes <input type="checkbox"/> Unknown (select only if oocyte source is unknown)

PATIENT MEDICAL EVALUATION

REASON FOR ART	
Quex ID	LEAD QUESTION
15	Reason for ART (Select all that apply): <input type="checkbox"/> Male infertility (select all that apply) <div style="display: flex; align-items: flex-start;"> <div style="flex: 1; border-right: 1px solid black; padding-right: 5px;"> <p style="text-align: center; margin: 0;">[SKIP IF MALE INFERTILITY NOT SELECTED]</p> </div> <div style="flex: 2; padding-left: 5px;"> <input type="checkbox"/> Medical condition <input type="checkbox"/> Genetic or chromosomal abnormality Specify_____ <input type="checkbox"/> Abnormal sperm parameters (select all that apply) <div style="margin-left: 20px;"> <input type="checkbox"/> Azoospermia, obstructive <input type="checkbox"/> Azoospermia, non-obstructive <input type="checkbox"/> Oligospermia, severe (<5 million/mL) <input type="checkbox"/> Oligospermia, moderate (5-15 million/mL) <input type="checkbox"/> Low motility (<40%) <input type="checkbox"/> Low morphology (4%) </div> <input type="checkbox"/> Other male factor (not included above) Specify_____ </div> </div> <input type="checkbox"/> History of endometriosis <input type="checkbox"/> Tubal ligation for contraception <input type="checkbox"/> Current or prior hydrosalpinx

	<p>[SKIP IF HYDROSALPINX NOT SELECTED]</p> <p><input type="checkbox"/> Communicating <input type="checkbox"/> Occluded <input type="checkbox"/> Unknown</p>
	<p><input type="checkbox"/> Other tubal disease (not current or historic hydrosalpinx)</p> <p><input type="checkbox"/> Ovulatory disorders</p>
	<p>[SKIP IF OVULATORY DISORDER NOT SELECTED]</p> <p><input type="checkbox"/> PCO <input type="checkbox"/> Other ovulatory disorders</p>
	<p><input type="checkbox"/> Diminished ovarian reserve</p> <p><input type="checkbox"/> Uterine factor</p> <p><input type="checkbox"/> Preimplantation Genetic Diagnosis as primary reason for ART</p> <p><input type="checkbox"/> Oocyte or Embryo Banking as reason for ART</p> <p><input type="checkbox"/> Indication for use of gestational carrier</p>
	<p>[SKIP IF GESTATIONAL CARRIER NOT INDICATED]</p> <p><input type="checkbox"/> Absence of uterus</p> <p><input type="checkbox"/> Significant uterine anomaly</p> <p><input type="checkbox"/> Medical contraindication to pregnancy</p> <p><input type="checkbox"/> Recurrent pregnancy loss</p> <p><input type="checkbox"/> Unknown</p>
	<p><input type="checkbox"/> Recurrent pregnancy loss</p> <p><input type="checkbox"/> Other reasons related to infertility (specify) _____</p> <p><input type="checkbox"/> Other reasons <u>not</u> related to infertility (specify) _____</p> <p><input type="checkbox"/> Unexplained infertility</p>
FEMALE PATIENT HISTORY AND PHYSICAL	
16	<p>[IF SEX OF PATIENT = MALE (FROM QUESTION #5) THEN SKIP #16-23]</p> <p>Height:</p> <p> _ _ Feet and/or _ _ Inches or _ _ _ _ Centimeters</p> <p>or</p> <p><input type="checkbox"/> Height unknown</p>
17	<p>Weight at the start of this cycle</p> <p> _ _ _ Pounds or _ _ _ Kilograms</p> <p>or</p> <p><input type="checkbox"/> Weight unknown</p>
18	<p>History of cigarette smoking:</p> <p>Did the patient smoke during the 3 months before the cycle started?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
19	<p>Any prior pregnancies?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
19A	<p>[SKIP IF NO PRIOR PREGNANCIES]</p> <p>If prior pregnancies reported and couple is not surgically sterile, enter months or years attempting pregnancy since last clinical pregnancy _ _ months and/or _ _ years</p> <p>[SKIP IF ANY PRIOR PREGNANCIES]</p> <p>If no prior pregnancies reported and couple is not surgically sterile, enter months attempting pregnancy _ _ months and/or _ _ years</p>
19B	<p>If prior pregnancies reported, how many _ _ </p>
19C	<p>SKIP IF NO PRIOR PREGNANCIES</p> <p>Number of prior full term births _ _ </p>
19D	<p>Number of prior preterm births _ _ </p>
19E	<p>Number of prior stillbirths _ _ </p>

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19F		Number of prior spontaneous abortions __ __
19G		Number of ectopic pregnancies __ __
20	Number of prior stimulations for ART: __ __	
21	Number of prior frozen ART cycles: __ __	
21A	SKIP IF NO PRIOR ART CYCLES	Did any of the prior ART cycles result in a live birth? <input type="radio"/> Yes <input type="radio"/> No
22	Patient maximum FSH level (MIU/mls): __ __ __ . __ __ Or FSH unknown: <input type="checkbox"/>	
23	Most recent AMH level (ng/mL): __ __ __ . __ __ Or AMH unknown: <input type="checkbox"/> Date of most recent AMH level __ __ - __ __ - __ __ __ __	

SOURCE AND CARRIER PROFILES

OOCYTE SOURCE PROFILE

Quex ID	LEAD QUESTION
24	OOCYTE SOURCE Date of Birth (mm/dd/yyyy): [FIELD PRE-FILLED IF OOCYTE SOURCE=PATIENT] __ __ - __ __ - __ __ __ __ OR age at earliest time oocytes were retrieved ____
25	OOCYTE SOURCE Ethnicity: Select one: <input type="radio"/> NOT Hispanic or Latino <input type="radio"/> Hispanic or Latino <input type="radio"/> Refused <input type="radio"/> Unknown
26	OOCYTE SOURCE Race (based on oocyte source self-report) Select all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native
26A	Select reason race not reported: <input type="radio"/> Refused <input type="radio"/> Unknown

PREGNANCY CARRIER PROFILE

27	Pregnancy carrier <input type="checkbox"/> Patient <input type="checkbox"/> Gestational carrier <input type="checkbox"/> None (oocyte or embryo banking cycle only)
28	[IF CARRIER=NONE THEN SKIP 28-31] or [IF CARRIER=PATIENT AND OOCYTE SOURCE=PATIENT THEN SKIP 28-31] Pregnancy carrier Date of Birth (mm/dd/yyyy): __ __ - __ __ - __ __ __ __ OR age at time of transfer ____
29	Pregnancy carrier Ethnicity: Select one: <input type="radio"/> NOT Hispanic or Latino

	<input type="radio"/> Hispanic or Latino <input type="radio"/> Refused <input type="radio"/> Unknown
30	Pregnancy carrier Race (based on gestational carrier self report) Select all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native
30A	Yes <input type="checkbox"/> Select reason race not reported: <input type="radio"/> Refused <input type="radio"/> Unknown

Quex ID	LEAD QUESTION
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31	SPERM SOURCE PROFILE
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31	Specify sperm source. Select all that apply. <input type="checkbox"/> Partner <input type="checkbox"/> Donor <input type="checkbox"/> Patient, if male <input type="checkbox"/> Unknown (select only if <u>all</u> sperm sources unknown for frozen)
32	SPERM source Date of Birth (mm/dd/yyyy): _ _ - _ _ - _ _ _ _ [FIELD PRE-FILLED IF SPERM SOURCE=MALE PATIENT] Or <input type="checkbox"/> Unknown
33	SPERM source Ethnicity: Select one: <input type="radio"/> NOT Hispanic or Latino <input type="radio"/> Hispanic or Latino <input type="radio"/> Refused <input type="radio"/> Unknown
34	SPERM source Race (based on patient self report) Select all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native
34A	Select reason race not reported: <input type="radio"/> Refused <input type="radio"/> Unknown

STIMULATION AND RETRIEVAL	
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Quex ID	LEAD QUESTION
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35	OVARIAN STIMULATION AND MEDICATIONS
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35	Was there stimulation for follicular development? <input type="radio"/> Yes <input type="radio"/> No [IF NO STIMULATION OR FROZEN CYCLE, SKIP #36-39]
36	Oral medication such as aromatase inhibitor or selective estrogen receptor modulator? <input type="radio"/> Yes <input type="radio"/> No
36A	[SKIP IF NO ORAL MEDS] Clomiphene dosage (Total mgs): _ _ _ _ _ . _ _ _ Letrozole dosage (Total mgs) _ _ _ _ _ . _ _ _ Other (specify) _____ dosage _ _ _ _ _ . _ _ _
37	Medication(s) containing FSH? <input type="radio"/> Yes <input type="radio"/> No

37A	[SKIP IF NO FSH MEDS]	Short-acting FSH (Total IUs): _ _ _ _ _ . _ _
37B		Long-acting FSH (Total mgs): _ _ _ _ _ . _ _
38	Medication(s) with LH/HCG activity? <input type="radio"/> Yes <input type="radio"/> No	
Quex ID	LEAD QUESTION	
39	GnRH Protocol Select the one <u>primary</u> protocol: <input type="radio"/> No GnRH protocol <input type="radio"/> GnRH Agonist Suppression <input type="radio"/> GnRH Agonist Flare <input type="radio"/> GnRH Antagonist Suppression	
CANCELLATION-1 (open only for fresh cycles)		
40	[IF OOCYTE/EMBRYO SOURCE = FROZEN THEN SKIP 40-45] Was this ART cycle canceled prior to retrieval? <input type="radio"/> Yes <input type="radio"/> No	
40A	Date cycle canceled (mm/dd/yyyy): _ _ - _ _ - _ _ _ _	
40B	[SKIP IF CYCLE NOT CANCELLED]	Select one primary reason cycle was canceled: <input type="checkbox"/> Low ovarian response <input type="checkbox"/> High ovarian response <input type="checkbox"/> Inadequate endometrial response <input type="checkbox"/> Concurrent illness <input type="checkbox"/> Withdrawal only for personal reasons <input type="checkbox"/> OTHER - specify _____
[IF CYCLE CANCELLED, STOP HERE]		
FRESH OOCYTE RETRIEVAL		
41	Date retrieval performed (mm/dd/yyyy): _ _ - _ _ - _ _ _ _	
42	Total number of patient oocytes retrieved: _ _	
43	Total number of donor oocytes retrieved: _ _	
44	Use of <u>retrieved</u> oocytes Select all that apply: <input type="checkbox"/> Used for this cycle <input type="checkbox"/> Oocytes frozen for future use <input type="checkbox"/> Oocytes shared with other patients <input type="checkbox"/> Embryos frozen for future use	
44A	[SKIP IF NO OOCYTES FROZEN]	Number of FRESH oocytes frozen for future use: _ _
COMPLICATIONS OF OVARIAN STIMULATION OR OOCYTE RETRIEVAL		
45	Were there any complications of ovarian stimulation or oocyte retrieval? <input type="radio"/> Yes <input type="radio"/> No	
45A	SKIP IF NO COMPLICATIONS	Select all complications that apply: <input type="checkbox"/> Infection <input type="checkbox"/> Hemorrhage requiring transfusion <input type="checkbox"/> Ovarian hyperstimulation requiring intervention or hospitalization <input type="checkbox"/> Medication side effect <input type="checkbox"/> Anesthetic complication <input type="checkbox"/> Thrombosis <input type="checkbox"/> Death of patient <input type="checkbox"/> Other - specify _____
45B	SKIP IF NO COMPLICATIONS	Did the complication(s) require hospitalization? <input type="radio"/> Yes <input type="radio"/> No

[IF OOCYTE BANKING CYCLE <u>ONLY</u> , STOP HERE]

SPERM RETRIEVAL	
46	Sperm status: <input type="checkbox"/> Fresh <input type="checkbox"/> Thawed <input type="checkbox"/> Mix of fresh and thawed
47	Sperm source utilized: <input type="radio"/> Ejaculated <input type="radio"/> Epididymal <input type="radio"/> Testis <input type="radio"/> Electroejaculation <input type="radio"/> Retrograde urine <input type="radio"/> Donor <input type="radio"/> Unknown
LABORATORY INFORMATION	
Quex ID	LEAD QUESTION
MANIPULATION	
48	Intracytoplasmic sperm injection (ICSI) performed on oocytes? <input type="radio"/> All oocytes <input type="radio"/> Some oocytes <input type="radio"/> No oocytes <input type="radio"/> Unknown
48A	<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> SKIP IF NO ICSI </div> <div> Indication for ICSI (select all that apply) <input type="radio"/> Prior failed fertilization <input type="radio"/> Poor fertilization <input type="radio"/> PGD <input type="radio"/> Abnormal semen parameters on day of fertilization <input type="radio"/> Low oocyte yield <input type="radio"/> Laboratory routine <input type="radio"/> Frozen cycle <input type="radio"/> Rescue ICSI <input type="radio"/> Other - specify _____ </div> </div>
49	In vitro maturation (IVM) performed on oocytes? <input type="radio"/> All oocytes <input type="radio"/> Some oocytes <input type="radio"/> No oocytes <input type="radio"/> Unknown
50	Pre-implantation genetic diagnosis or screening performed on embryos? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
50A	Total number of 2PN: __ __
50B	<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> SKIP IF PGD/PGS NOT PERFORMED OR UNKNOWN </div> <div> Reason(s) for pre-implantation genetic diagnosis or screening (Select all that apply): <input type="checkbox"/> Either genetic parent is a known carrier of a gene mutation or a chromosomal abnormality <input type="checkbox"/> Aneuploidy screening of the embryos <input type="checkbox"/> Elective Gender Determination <input type="checkbox"/> Other screening of the embryos </div> </div>
50C	<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> SKIP IF PGD/PGS NOT PERFORMED OR UNKNOWN </div> <div> Technique(s) used for pre-implantation genetic diagnosis or screening (Select all that apply): <input type="checkbox"/> Polar Body Biopsy <input type="checkbox"/> Blastomere Biopsy <input type="checkbox"/> Blastocyst Biopsy <input type="checkbox"/> Unknown </div> </div>
51	Assisted hatching performed on embryos? <input type="radio"/> All embryos <input type="radio"/> Some embryos <input type="radio"/> No embryos <input type="radio"/> Unknown

52	Was this a research cycle? <input type="radio"/> Yes Enter SART approval code _____ <input type="radio"/> No	
52A	SKIP IF NOT RESEARCH CYCLE	Study type: <input type="checkbox"/> Device study <input type="checkbox"/> Protocol study <input type="checkbox"/> Pharmaceutical study <input type="checkbox"/> Laboratory technique <input type="checkbox"/> Other research
		If 'Other', please specify _____
[IF EMBRYO BANKING CYCLE ONLY, SKIP TO #59, THEN STOP]		
TRANSFER		
Quex ID	LEAD QUESTION	
CANCELLATION-II		
53	Was a transfer attempted? <input type="radio"/> Yes <input type="radio"/> No	
53A	Select one primary reason no transfer was attempted: <input type="checkbox"/> Low ovarian response <input type="checkbox"/> High ovarian response <input type="checkbox"/> Failure to survive oocyte thaw <input type="checkbox"/> Inadequate endometrial response <input type="checkbox"/> Concurrent illness <input type="checkbox"/> Withdrawal only for personal reasons <input type="checkbox"/> Unable to obtain sperm specimen <input type="checkbox"/> Insufficient embryos <input type="checkbox"/> OTHER - specify _____	
[IF TRANSFER NOT ATTEMPTED, STOP HERE]		
GENERAL TRANSFER DETAILS		
54	Date of embryo transfer (mm/dd/yyyy): __ __ - __ __ - __ __ __ __	
55	Endometrial thickness at trigger: __ __ mm	
FRESH EMBRYO TRANSFER DETAILS		
56	[IF NO FRESH EMBRYOS TRANSFERRED, SKIP #57-58] Number of FRESH embryos transferred to uterus: __ __	
57	[SKIP #57 FOR MIXED CYCLE] If only <u>one</u> fresh embryo was transferred to the uterus, was this an <u>elective</u> single embryo transfer? <input type="radio"/> Yes <input type="radio"/> No	
58A-X	Quality of embryo #1-X <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Unknown	
	Date of oocyte retrieval for embryo #1-X __ __ - __ __ - __ __ __ __	
59	Number of FRESH embryos cryopreserved: __ __ [STOP HERE FOR EMBRYO BANKING ONLY CYCLE]	
THAWED EMBRYO TRANSFER DETAILS		
60	Number of FROZEN or THAWED embryos available on day of transfer: __ __	
61	Number of THAWED embryos transferred to uterus: __ __ [IF NO THAWED EMBRYOS TRANSFERRED, SKIP #62]	

62	[SKIP #63 FOR MIXED CYCLE] If only <u>one</u> thawed embryo was transferred to the uterus, was this an <u>elective</u> single embryo transfer? ○ Yes ○ No
62A-X	Quality of embryo #1-X <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Unknown
	Date of oocyte retrieval for embryo #1-X __ _ - __ _ - __ _ _ _
63	Number of THAWED embryos cryopreserved (re-frozen): __ _
GIFT/ZIFT/TET TRANSFER DETAILS	
64	[SKIP IF IVF CYCLE] Number of oocytes or embryos transferred to the FALLOPIAN TUBE: __ _

TREATMENT OUTCOME (only opens if transfer >0)

Quex ID	LEAD QUESTION
OUTCOME OF TRANSFER	
65	Outcome of treatment cycle: <input type="checkbox"/> Not pregnant <input type="checkbox"/> Biochemical only <input type="checkbox"/> Clinical intrauterine gestation <input type="checkbox"/> Ectopic <input type="checkbox"/> Heterotopic <input type="checkbox"/> Unknown [IF NOT PREGNANT, BIOCHEMICAL ONLY, ECTOPIC, OR HETEROTOPIC, STOP HERE]
66	Maximum fetal hearts on ultrasound performed before 7 weeks or prior to reduction: __ _ <input type="checkbox"/> No ultrasound performed before 7 weeks gestation
66A	[SKIP IF NO U/S] Date ultrasound with max. number of fetal hearts observed before 7 weeks (mm/dd/yyyy): __ _ - __ _ - __ _ _ _
66B	[SKIP IF NO U/S] If 2 or more fetal hearts, any monochorionic twins or multiples? ○ Yes ○ No ○ Unknown

PREGNANCY OUTCOME (only opens if pregnancy = yes)

Quex ID	LEAD QUESTION
OUTCOME OF PREGNANCY	
67	Outcome of pregnancy: <input type="checkbox"/> Live birth <input type="checkbox"/> Spontaneous abortion <input type="checkbox"/> Stillbirth <input type="checkbox"/> Induced abortion <input type="checkbox"/> Maternal death prior to birth <input type="checkbox"/> Outcome unknown
68	Date of pregnancy outcome (mm/dd/yyyy): __ _ - __ _ - __ _ _ _ NOTE: If multiple births cover more than one date, enter date of first born.
68A	Method of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean section
69	Source of information confirming pregnancy outcome: (Select all that apply) <input type="checkbox"/> Verbal confirmation from patient <input type="checkbox"/> Written confirmation from patient <input type="checkbox"/> Verbal confirmation from physician or hospital

	<input type="checkbox"/> Written confirmation from physician or hospital
BIRTH INFORMATION	
70	Number of infants born: _ _
71A-X	Birth Status infant #1-X <input type="checkbox"/> Live birth <input type="checkbox"/> Stillbirth <input type="checkbox"/> Unknown
72A-X	Gender infant #1-X <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
73A-X	Weight in pounds and ounces, or grams infant #1-X _ _ lbs and _ _ oz. OR _ _ _ _ g OR <input type="checkbox"/> Weight unknown
74A-X	Birth defects (select all that apply) infant #1-X <input type="checkbox"/> None <input type="checkbox"/> Cleft lip/palate <input type="checkbox"/> Genetic defect/chromosomal abnormality <input type="checkbox"/> Neural tube defect <input type="checkbox"/> Cardiac defect <input type="checkbox"/> Limb defect <input type="checkbox"/> Other (specify) OR <input type="checkbox"/> Unknown
75A-X	For liveborn infant, did neonatal death occur? infant #1-X <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown