**National ART Surveillance System**

**NASS 2.0**

**(Proposed for 2016)**

**DRAFT**

INITIAL REPORTING: PATIENT PROFILE (prosPEctive)

|  |  |  |  |
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| **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:** ⃝ Male ⃝ Female | | |
| 6 | **Cycle Start Date**|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_| | | |
|  | **RESIDENCY** | | |
| 7 | **At the start of the cycle, is patient residency primarily in U.S.?**  ⃝Yes  ⃝ No  ⃝ Refused | | |
| 7A | | **U.S. state of primary residence:**  **City of primary residence**  **U.S. zip code at primary residence** |\_\_|\_\_|\_\_|\_\_|\_\_|  **OR**  **Country of primary residence:** | |
|  | **INTENT** | | |
| 8 | **Intended type of ART? Select all that apply:**  IVF: Transcervical  GIFT: Gametes to tubes  ZIFT: Zygotes to tubes or TET: tubal embryo transfer  Oocyte or embryo banking | | |
| 9 | **[SKIP IF NOT A BANKING ONLY CYCLE]** | | **If cycle is for banking only, specify banking type (select all that apply):**  Embryo banking  Autologous oocyte banking  Donor oocyte banking |
| 9A | **Indicate anticipated duration of oocyte banking SKIP IF EMBRYO BANKING ONLY**  Short term (<12 months)  Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments  Long term (≥12 months) banking for other reasons |
| 9B | **Indicate anticipated duration of embryo banking SKIP IF OOCYTE BANKING ONLY**  Short term (<12 months)   * Delay of transfer to obtain genetic information * Delay of transfer for other reasons   Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments  Long term (≥12 months) banking for other reasons |
| 10 | **Intended embryo source (select all that apply):**  Patient embryos  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:**  Patient oocytes  Fresh oocytes  Frozen oocytes  Donor oocytes  Fresh oocytes  Frozen oocytes  **If intent is to use FROZEN EMBRYOS, specify intended oocyte source. Select all that apply:**  Patient oocytes  Fresh oocytes  Frozen oocytes  Donor oocytes  Fresh oocytes  Frozen oocytes  Unknown (select only if oocyte source is unknown) | | |
| 11 | **Specify intended sperm source. Select all that apply. [SKIP IF DONOR EMBRYO IS INTENDED SOURCE]**  Partner  Donor  Patient, if male  Unknown (select only if all sperm sources unknown for frozen) | | |
| 12 | **Pregnancy carrier**  Patient  Gestational carrier  None (oocyte or embryo banking cycle only) | | |

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| CYCLE INFORMATION (NOT prosPEctive FROM HERE FORWARD) | |
| **Quex ID** | **LEAD QUESTION** |
| 13 | **Type of ART performed? Select all that apply:**  IVF: Transcervical  GIFT: Gametes to tubes  ZIFT: Zygotes to tubes or TET: tubal embryo transfer  Oocyte or embryo banking |
| 14 | **Embryo source (select all that apply):**  Patient embryos  Donor embryos **[IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #15]** |
| 14A | **If FRESH EMBRYOS were used, specify intended oocyte source. Select all that apply:**  Patient oocytes  Fresh oocytes  Frozen oocytes  Donor oocytes  Fresh oocytes  Frozen oocytes  **If FROZEN EMBRYOS were used, specify intended oocyte source. Select all that apply:**  Patient oocytes  Fresh oocytes  Frozen oocytes  Donor oocytes  Fresh oocytes  Frozen oocytes  Unknown (select only if oocyte source is unknown) |

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| **PATIENT MEDICAL EVALUATION** | | | | |
|  | | REASON FOR ART | | |
| **Quex ID** | | **LEAD QUESTION** | | |
| 15 | | **Reason for ART (Select all that apply):**  Male infertility (select all that apply) | | |
| **[SKIP IF MALE INFERTILITY NOT SELECTED]** | | * Medical condition * Genetic or chromosomal abnormality Specify\_\_\_\_\_\_\_\_\_\_\_ * Abnormal sperm parameters (select all that apply)   Azoospermia, obstructive  Azoospermia, non-obstructive  Oligospermia, severe (<5 million/mL)  Oligospermia, moderate (5-15 million/mL)  Low motility (<40%)  Low morphology (4%)   * Other male factor (not included above) Specify\_\_\_\_\_\_\_\_\_\_\_ |
| History of endometriosis  Tubal ligation for contraception  Current or prior hydrosalpinx | | |
| **[SKIP IF HYDROSALPINX NOT SELECTED]** | | Communicating  Occluded  Unknown |
| Other tubal disease (not current or historic hydrosalpinx)  Ovulatory disorders | | |
| **[SKIP IF OVULATORY DISORDER NOT SELECTED]** | | PCO  Other ovulatory disorders |
| Diminished ovarian reserve  Uterine factor  Preimplantation Genetic Diagnosis as primary reason for ART  Oocyte or Embryo Banking as reason for ART  Indication for use of gestational carrier | | |
| **[SKIP IF GESTATIONAL CARRIER NOT INDICATED]** | | * Absence of uterus * Signiﬁcant uterine anomaly * Medical contraindication to pregnancy * Recurrent pregnancy loss * Unknown |
| Recurrent pregnancy loss  Other reasons related to infertility (specify) \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Other reasons not related to infertility (specify) \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_  Unexplained infertility | | |
|  | FEMALE PATIENT HISTORY AND PHYSICAL | | | |
| 16 | **[IF SEX OF PATIENT = MALE (FROM QUESTION #5) THEN SKIP #16-23]**  **Height:**  |\_\_| Feet and/or |\_\_|\_\_| Inches or |\_\_|\_\_|\_\_|\_\_| Centimeters  or  Height unknown | | | |
| 17 | **Weight at the start of this cycle**  |\_\_|\_\_|\_\_|\_\_| Pounds or |\_\_|\_\_|\_\_|\_\_| Kilograms  or  Weight unknown | | | |
| 18 | **History of cigarette smoking:**  Did the patient smoke during the 3 months before the cycle started?  Yes  No  Unknown | | | |
| 19 | **Any prior pregnancies?**  ⃝Yes  ⃝ No | | | |
| 19A | **[SKIP IF NO PRIOR PREGNANCIES]**  **If prior pregnancies reported and couple is not surgically sterile, enter months or years attempting pregnancy since last clinical pregnancy |\_\_|\_\_|\_\_| months and/or |\_\_|\_\_| years**  **[SKIP IF ANY PRIOR PREGNANCIES]**  **If no prior pregnancies reported and couple is not surgically sterile, enter months attempting pregnancy**  **|\_\_|\_\_|\_\_| months and/or |\_\_|\_\_| years** | | | |
| 19B | **SKIP IF NO PRIOR PREGNANCIES** | | **If prior pregnancies reported, how many |\_\_|\_\_|** | |
| 19C | **Number of prior full term births |\_\_|\_\_|** | |
| 19D | **Number of prior preterm births |\_\_|\_\_|** | |
| 19E | **Number of prior stillbirths |\_\_|\_\_|** | |
| 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? ⃝Yes ⃝ No** | |
| 22 | **Patient maximum FSH level (MIU/mls): |\_\_|\_\_|\_\_| . |\_\_|\_\_|**  Or FSH unknown: | | | |
| 23 | **Most recent AMH level (ng/mL): |\_\_|\_\_|\_\_| . |\_\_|\_\_|**  Or AMH unknown:  **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:**  ⃝ NOT Hispanic or Latino  ⃝ Hispanic or Latino  ⃝ Refused  ⃝ Unknown | | |
| 26 | | **OOCYTE SOURCE Race (based on oocyte source self-report)**  **Select all that apply:**  White  Black or African American  Asian  Native Hawaiian or other Pacific Islander  American Indian or Alaska Native | | |
| 26A | |  | | **Select reason race not reported:**  ⃝ Refused  ⃝ Unknown |

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|  | PREGNANCY CARRIER PROFILE | | |
| 27 | **Pregnancy carrier**  Patient  Gestational carrier  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:**  ⃝ NOT Hispanic or Latino  ⃝ Hispanic or Latino  ⃝ Refused  ⃝ Unknown | | |
| 30 | **Pregnancy carrier Race (based on gestational carrier self report)**  **Select all that apply:**  White  Black or African American  Asian  Native Hawaiian or other Pacific Islander  American Indian or Alaska Native | | |
| 30A | Yes |  | **Select reason race not reported:**  ⃝ Refused  ⃝ Unknown |

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| **Quex ID** | | **LEAD QUESTION** | | | | | |
|  | | SPERM SOURCE PROFILE | | | | | |
| 31 | | **Specify sperm source. Select all that apply.**  Partner  Donor  Patient, if male  Unknown (select only if all sperm sources unknown for frozen) | | | | | |
| 32 | | **SPERM source Date of Birth (mm/dd/yyyy):**|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|  **[FIELD PRE-FILLED IF SPERM SOURCE=MALE PATIENT]**  Or  Unknown | | | | | |
| 33 | | **SPERM source Ethnicity:**  **Select one:**  ⃝ NOT Hispanic or Latino  ⃝ Hispanic or Latino  ⃝ Refused  ⃝ Unknown | | | | | |
| 34 | | **SPERM source Race (based on patient self report)**  **Select all that apply:**  White  Black or African American  Asian  Native Hawaiian or other Pacific Islander  American Indian or Alaska Native | | | | | |
| 34A | |  | | | **Select reason race not reported:**  ⃝ Refused  ⃝ Unknown | | |
| **STIMULATION AND RETRIEVAL** | | | | | | | |
| **Quex ID** | | **LEAD QUESTION** | | | | | |
|  | | **OVARIAN STIMULATION AND MEDICATIONS** | | | | | |
| 35 | | **Was there stimulation for follicular development?**  ⃝Yes ⃝ No  **[IF NO STIMULATION OR FROZEN CYCLE, SKIP #36-39]** | | | | | |
| 36 | | **Oral medication such as aromatase inhibitor or selective estrogen receptor modulator?**  ⃝Yes ⃝ No | | | | | |
| 36A | | **[SKIP IF NO ORAL MEDS]** | | | **Clomiphene dosage (Total mgs): |\_\_|\_\_|\_\_|\_\_|\_\_| . |\_\_|\_\_|**  **Letrozole dosage (Total mgs) |\_\_|\_\_|\_\_|\_\_|\_\_| . |\_\_|\_\_|**  **Other (specify)\_\_\_\_\_\_\_\_\_ dosage |\_\_|\_\_|\_\_|\_\_|\_\_| . |\_\_|\_\_|** | | |
| 37 | | **Medication(s) containing FSH?**  **⃝Yes ⃝ 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?**  **⃝Yes ⃝ No** | | | | | |
| **Quex ID** | | **LEAD QUESTION** | | | | | |
| 39 | | **GnRH Protocol**  **Select the one primary protocol:**  **⃝** No GnRH protocol  **⃝** GnRH Agonist Suppression  **⃝** GnRH Agonist Flare  **⃝** GnRH Antagonist Suppression | | | | | |
|  | **CANCELLATION-I (open only for fresh cycles)** | | | | | | |
| 40 | **[IF OOCYTE/EMBRYO SOURCE = FROZEN THEN SKIP 40-45]**  **Was this ART cycle canceled prior to retrieval?**  **⃝**Yes ⃝ No | | | | | | |
| 40A | **[SKIP IF CYCLE NOT CANCELLED]** | | | **Date cycle canceled (mm/dd/yyyy): |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|** | | | |
| 40B | **Select one primary reason cycle was canceled:**  **Low ovarian response**  **High ovarian response**  **Inadequate endometrial response**  **Concurrent illness**  **Withdrawal only for personal reasons**  **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 retrieved oocytes Select all that apply:**  Used for this cycle  Oocytes frozen for future use  Oocytes shared with other patients  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?**  **⃝**Yes ⃝ No | | | | | | |
| 45A | **SKIP IF NO COMPLICATIONS** | | **Select all complications that apply:**  Infection  Hemorrhage requiring transfusion  Ovarian hyperstimulation requiring intervention or hospitalization  Medication side effect  Anesthetic complication  Thrombosis  Death of patient  Other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| 45B | **SKIP IF NO COMPLICATIONS** | | | | | **Did the complication(s) require hospitalization?**  ⃝Yes ⃝ No | |
|  | **[IF OOCYTE BANKING CYCLE ONLY, STOP HERE]** | | | | | | |

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|  | SPERM RETRIEVAL | | | |
| 46 | **Sperm status:**  Fresh  Thawed  Mix of fresh and thawed | | | |
| 47 | **Sperm source utilized:**  **⃝** Ejaculated  **⃝** Epididymal  **⃝** Testis  **⃝** Electroejaculation  **⃝** Retrograde urine  **⃝** Donor  **⃝** Unknown | | | |
| **LABORATORY INFORMATION** | | | | |
| **Quex ID** | **LEAD QUESTION** | | | |
|  | MANIPULATION | | | |
| 48 | **Intracytoplasmic sperm injection (ICSI) performed on oocytes?**  **⃝** All oocytes  **⃝** Some oocytes  **⃝** No oocytes  **⃝** Unknown | | | |
| 48A | **SKIP IF NO ICSI** | | **Indication for ICSI (select all that apply)**  **⃝** Prior failed fertilization  **⃝** Poor fertilization  **⃝** PGD  **⃝** Abnormal semen parameters on day of fertilization  **⃝** Low oocyte yield  **⃝** Laboratory routine  **⃝** Frozen cycle  **⃝**  Rescue ICSI  **⃝** Other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 49 | **In vitro maturation (IVM) performed on oocytes?**  **⃝** All oocytes  **⃝** Some oocytes  **⃝**  No oocytes  **⃝** Unknown | | | |
| 50 | **Pre-implantation genetic diagnosis or screening performed on embryos?**  ⃝ Yes  ⃝ No  ⃝ Unknown | | | |
| 50A | **SKIP IF PGD/PGS NOT PERFORMED OR UNKNOWN** | | **Total number of 2PN:** |\_\_|\_\_| | |
| 50B | **Reason(s) for pre-implantation genetic diagnosis or screening (Select all that apply):**  Either genetic parent is a known carrier of a gene mutation or a chromosomal abnormality  Aneuploidy screening of the embryos  Elective Gender Determination  Other screening of the embryos | |
| 50C | **Technique(s) used for pre-implantation genetic diagnosis or screening (Select all that apply):**  Polar Body Biopsy  Blastomere Biopsy  Blastocyst Biopsy  Unknown | |
| 51 | **Assisted hatching performed on embryos?**  **⃝** All embryos  ⃝ Some embryos  **⃝** No embryos  ⃝ Unknown | | | |
| 52 | **Was this a research cycle?**  **⃝** Yes Enter SART approval code\_\_\_\_\_\_\_\_\_\_\_\_\_  ⃝ No | | | |
| 52A | **SKIP IF NOT RESEARCH CYCLE** | | **Study type:**  Device study  Protocol study  Pharmaceutical study  Laboratory technique  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?**  ⃝Yes ⃝ No | | |
| 53A | |  | | **Select one primary reason no transfer was attempted:**  Low ovarian response  High ovarian response  Failure to survive oocyte thaw  Inadequate endometrial response  Concurrent illness  Withdrawal only for personal reasons  Unable to obtain sperm specimen  Insufficient embryos  OTHER – specify **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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|  | **[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 one fresh embryo was transferred to the uterus, was this an elective single embryo transfer?**  ⃝Yes ⃝ No | | |
| 58A-X | **Quality of embryo #1–X**  Good  Fair  Poor  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 one thawed embryo was transferred to the uterus, was this an elective single embryo transfer?**  ⃝Yes ⃝ No | | |
| 62A-X | **Quality of embryo #1–X**  Good  Fair  Poor  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: |\_\_|\_\_|** | | |

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| **TREATMENT OUTCOME (only opens if transfer >0)** | | | |
| **Quex ID** | **LEAD QUESTION** | | |
|  | OUTCOME OF TRANSFER | | |
| 65 | **Outcome of treatment cycle:**  Not pregnant  Biochemical only  Clinical intrauterine gestation  Ectopic  Heterotopic  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: |\_\_|\_\_|**  **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:**  Live birth  Spontaneous abortion  Stillbirth  Induced abortion  Maternal death prior to birth  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**  **Vaginal**  **Cesarean section** | | |
| 69 | **Source of information confirming pregnancy outcome:**  **(Select all that apply)**  Verbal confirmation from patient  Written confirmation from patient  Verbal confirmation from physician or hospital  Written confirmation from physician or hospital | | |
|  | BIRTH INFORMATION | |
| 70 | **Number of infants born: |\_\_|\_\_|** | | |
| 71A-X | **Birth Status infant #1-X**  Live birth Stillbirth Unknown | | |
| 72A-X | **Gender infant #1-X**  Male  Female  Unknown | | |
| 73A-X | **Weight in pounds and ounces, or grams infant #1-X**  **|\_\_|\_\_| lbs and |\_\_|\_\_| oz. OR |\_\_|\_\_|\_\_|\_\_| g**  **OR**  **Weight unknown** | | |
| 74A-X | **Birth defects (select all that apply) infant #1-X**  None  Cleft lip/palate  Genetic defect/chromosomal abnormality  Neural tube defect  Cardiac defect  Limb defect  Other (specify) OR Unknown | | |