

# Centers for Birth Defects Research and Prevention Supplemental Stillbirth Computer-Assisted Telephone Interview

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Questionnaire Version 1, Draft 2.0

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## OPENING STATEMENT

In this interview we will ask you questions mainly about your pregnancy with {name of infant}, who was born on {infant's birth date} (**for liveborns**)/ that ended on {pregnancy end date} (**for stillbirths**).

## Section A: PREVIOUS PREGNANCY HISTORY

I am going to start by asking you about your **previous pregnancy** experiences.

A1. Has a prior pregnancy ended in a stillbirth?

- a. Yes → CONTINUE TO A2
- b. No → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

A2. Was an autopsy or other type of exam done for the baby who died?

- a. Yes → CONTINUE TO A3
- b. No → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

A3. Did a healthcare provider tell you about the autopsy results or why he/she thought the baby died?

- a. Yes → CONTINUE TO A4
- b. No → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

A4. What was the reason? \_\_\_\_\_

## INDEX PREGNANCY: PREGNANCY-SPECIFIC CONDITIONS

Now, I'm going to ask you about **your pregnancy** experiences for your pregnancy with {name of infant}, who was born on {infant's birth date} (**for liveborns**)/ that ended on {pregnancy end date} (**for stillbirths**).

## Section B. MATERNAL PERCEPTION OF FETAL MOVEMENTS

B1. Do you remember the month when the baby first started moving?

- a. Yes → CONTINUE TO B2
- b. No → SKIP TO B3
- c. DK → SKIP TO B3
- d. RF → SKIP TO B3

B2. In what month did the movements start? [RECORD ONE]

- a. \_\_\_ weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd/yyyy]
- e. DK
- f. RF

B3. During the last three months you were pregnant, did you notice any change in the frequency of fetal movements?

- a. Yes → CONTINUE TO B4
- b. No → SKIP TO B7
- c. DK → SKIP TO B7
- d. RF → SKIP TO B7

B4. Did the frequency of movements

- a. Increase? → SKIP TO B7
- b. Stay the same? → SKIP TO B7
- c. Decrease? → CONTINUE TO B5
- d. DK → SKIP TO B7
- e. RF → SKIP TO B7

B5. When was the first time you experienced reduced fetal movement in your pregnancy? [RECORD ONE]

- g. \_\_\_ weeks OR
- h. \_\_\_ months OR
- i. \_\_\_ trimester OR
- j. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd/yyyy]
- k. DK
- l. RF

B6. Was the reduced fetal movement severe enough for you to call, mention, or notify your healthcare provider?

- a. YES
- b. NO
- c. DK
- d. RF

B7. During the last three months you were pregnant, did you notice any change in the strength of fetal movement?

- a. Yes → CONTINUE TO B8
- b. No → SKIP TO B11
- c. DK → SKIP TO B11
- d. RF → SKIP TO B11

B8. Did the strength of the movements

- e. Increase? →SKIP TO B11
- f. Stay the same? →SKIP TO B11
- g. Decrease? →CONTINUE TO B9
- h. DK →SKIP TO B11
- i. RF →SKIP TO B11

B9. When was the first time you noticed a decrease in the strength of the fetal movements?

- a. \_\_\_weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ \_\_\_ \_\_\_ date [mm/dd /yyyy]
- e. DK
- f. RF

B10. Was the decrease in the strength of fetal movement severe enough for you to call, to mention, or notify your healthcare provider?

- a. YES
- b. NO
- c. DK
- d. RF

B11. Did you ever notice that the fetal movements had completely stopped?

- a. Yes → GO TO B12
- b. No → SKIP TO B13
- c. DK → SKIP TO B13
- d. RF → SKIP TO B13

B12. When was the first time you noticed that the fetal movements had completely stopped?

- a. \_\_\_weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ \_\_\_ \_\_\_ date [mm/dd /yyyy]
- e. DK
- f. RF

B13. During the last three months of your pregnancy, did you feel rhythmic movements or your baby having hiccups (short jerking movements occurring at regular intervals, for a period of time)?

- a. Yes
- b. No
- c. DK
- d. RF

## Section C. MATERNAL SLEEPING POSITION

C1. What is your usual sleep position when you are not pregnant?

- a. On back
- b. On stomach, facing down
- c. Left
- d. Right
- e. Combination of positions
- f. DK
- g. RF

C2. What was your usual sleep position during the last month of your pregnancy?

- a. On back
- b. On stomach, facing down
- c. Left
- d. Right
- e. Combination of positions
- f. DK
- g. RF

## Section D. FETAL GROWTH

D1. Did a healthcare provider tell you that the baby was not growing normally during pregnancy?

- a. Yes → CONTINUE TO D2
- B. NO → SKIP TO D3
- C. DK → SKIP TO D3
- D. RF → SKIP TO D3

D2. What did the healthcare provider tell you? \_\_\_\_\_

D3. Did you have an ultrasound during your pregnancy that showed that your baby's growth was restricted?

- a. YES → When was it done? \_\_\_\_ weeks OR \_\_\_\_ months OR \_\_\_\_ trimester OR  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_ date [mm/dd /yyyy]
- b. NO
- c. DK
- d. RF

D4. Did you have any tests during your pregnancy that showed any problems involving the placenta or umbilical cord, such as placenta previa or cord knots?

- a. YES → What problem was found? \_\_\_\_\_  
Anything else? \_\_\_\_\_
- b. NO
- c. DK
- d. RF

**IF OUTCOME OF THE PARTICIPANT'S PREGNANCY WAS LIVEBORN, SKIP TO SECTION E (VAGINAL BLEEDING)**

**IF OUTCOME OF THE PARTICIPANT'S PREGNANCY WAS STILLBIRTH, CONTINUE WITH D5**

D5. Was an autopsy or other type of exam done for the baby who died?

- a. Yes → CONTINUE TO D6
- b. No → SKIP TO D8
- c. Not sure → SKIP TO D8
- D. RF → SKIP TO D8

D6. Did a healthcare provider tell you about the autopsy results or why he/she thought the baby died?

- a. Yes → CONTINUE TO D7
- b. No → SKIP TO D8
- c. Not sure → SKIP TO D8
- D. RF → SKIP TO D8

D7. What were you told was the reason? \_\_\_\_\_

D8. Did a healthcare provider do any genetic tests because the baby died?

- a. Yes → CONTINUE TO D9
- b. No → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- D. RF → SKIP TO NEXT SECTION

D9. Do you remember which tests were done?

- a. Yes → CONTINUE TO D10
- b. No → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

D10. What were the results? \_\_\_\_\_

## **Section E. VAGINAL BLEEDING**

E1. At any time during your pregnancy, did you experience more than one pad's worth of bleeding during a one-day period?

- a. YES → CONTINUE TO E2
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

E2. When was the first time you experienced this amount of bleeding in your pregnancy? [RECORD ONE]

- a. \_\_\_ weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy]
- e. DK
- f. RF

E3. Before delivery, when was the last time you experienced this amount of bleeding? [RECORD ONE]

- a. \_\_\_ weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] OR
- e. DK
- f. RF

E4. Was the bleeding severe enough for you to call, to mention, or to notify your healthcare provider?

- a. YES
- b. NO
- c. DK
- d. RF

## Section F. LOSS OF AMNIOTIC FLUID

F1. At any time during your pregnancy, did you experience enough leaking fluid to wear a pad?

- a. YES → CONTINUE TO F2
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

F2. When was the first time you experienced leaking fluid in your pregnancy? [RECORD ONE]

- a. \_\_\_ weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] OR
- e. DK
- f. RF

F3. Was the leaking fluid severe enough for you to call, to mention, or to notify your healthcare provider?

- a. YES
- b. NO
- c. DK
- d. RF



## Section G. ABDOMINAL PAIN

G1. During this pregnancy, did you experience severe abdominal pain?

- a. Yes → CONTINUE TO G2
- b. No → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

G2. When was the first time you experienced severe abdominal pain in your pregnancy? [RECORD ONE]

- a. \_\_\_ weeks OR
- b. \_\_\_ months OR
- c. \_\_\_ trimester OR
- d. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy]
- e. DK
- f. RF

G3. Was this abdominal pain severe enough for you to call, to mention, or to notify your healthcare provider?

- a. Yes
- b. No
- c. DK
- d. RF

## INDEX PREGNACY: SPECIFIC EXPOSURES

### Section H. SPECIFIC EXPOSURES

H1. Did you take any medications to maintain your pregnancy or to prevent premature delivery; examples of such medications: 17-hydroxyprogesterone, aspirin, magnesium sulfate?

- a. Yes → What did you take? \_\_\_\_\_  
Start date \_\_\_\_\_ Stop date \_\_\_\_\_  
Anything else? \_\_\_\_\_
- b. No
- c. DK
- d. RF

H2. At any time from {second trimester start date} until the end of your pregnancy, did you smoke cigarettes?

- a. YES → GO TO H2a
- b. NO → SKIP TO H3
- c. DK → SKIP TO H3
- d. RF → SKIP TO H3

- H2a. During which months did you smoke?
- a. MONTH OF PREGNANCY (P4 /P5 / P6 / P7 / P8 /P9)
  - g. DK
  - h. RF

- H2b. How many cigarettes did you smoke per day?
- a. NUMBER \_\_\_\_\_
  - b. DK
  - c. RF

H3. At any time from {second trimester start date} until the end of your pregnancy, did you use electronic cigarettes, also known as e-cigarettes?

- a. YES → IF YES, GO TO H3a
- b. NO → SKIP TO H4
- c. DK → SKIP TO H4
- d. RF → SKIP TO H4

H3a. How often did you use e-cigarettes?

- a. EVERYDAY
- b. SOMEDAYS
- c. RARELY
- d. DK
- e. RF

H4. From {second trimester start date} until the end of your pregnancy, did you drink any wine, beer, mixed drinks or shots of liquor?

- a. YES → GO TO H4a
- b. NO → SKIP TO H5
- c. DK → SKIP TO H5
- d. RF → SKIP TO H5

H4a. During which months did you drink any alcoholic beverages?

- a. \_\_\_\_\_ (P4, P5, P6, P7, P8, P9)
- b. DK
- c. RF

H4b. What was the greatest number of drinks you had on one occasion during this time period? We define one drink as one beer, one glass of wine, one mixed drink, or one shot of liquor.

- a. NUMBER \_\_\_\_\_
- b. DK
- c. RF

H5. During your pregnancy, did any healthcare worker ever suspect you had exposure to carbon monoxide (from causes such as smoke from a fire, using faulty water heaters, using gas powered tools, vehicles, or poorly ventilated areas, car exhaust.)

- a. Yes
- b. No
- c. DK
- d. RF

## ILLNESSES AND THEIR TREATMENT

**Introduction:** During your previous telephone interview, we focused on the first trimester of your pregnancy. In this part of the interview, we will ask about some of the previously-covered topics, but this time our interest is mostly in the later period of your pregnancy, from the beginning of your second trimester until the end of your pregnancy. We will also cover some new topics. If you filled out the medication worksheet that we sent you earlier, it will be helpful if you have it in front of you when answering these questions.

**Note:** A medication worksheet covering the second and third trimesters will be sent with the introductory materials.

These questions will require the interviewer to have access to the participant's responses in the Primary CATI.

### Section I. DIABETES

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF DIABETES [PRIMARY CATI F1 = NO, DK, RF] → SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF DIABETES [PRIMARY CATI F1 = YES] → READ:

You previously told us that you had diabetes. Now I would like to ask some additional questions about your diabetes and any medications you may have taken to treat your diabetes from the beginning of your second trimester, that is from {second trimester start date}, until the end of your pregnancy.

- I1. What type of diabetes did you or do you currently have? Was it [READ LIST]
  - a. Gestational, that is, during pregnancy only → CONTINUE TO I2
  - b. Insulin-dependent diabetes, also called Type 1, or Juvenile → SKIP TO I4
  - c. Non-insulin-dependent diabetes, also called Type 2, or Adult onset → SKIP TO I4
  - d. DK → SKIP TO I4

- e. RF → SKIP TO I4
12. When were you first diagnosed with gestational diabetes? [READ LIST, a-c]
- a. During a previous pregnancy only → SKIP TO NEXT SECTION
  - b. During this [index] pregnancy only → CONTINUE TO I3
  - c. During this [index] pregnancy and a previous pregnancy → CONTINUE TO I3
  - d. DK → SKIP TO I4
  - e. RF → SKIP TO I4
13. When was gestational diabetes diagnosed during your [index] pregnancy?
- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd/yyyy]
  - b. Month of pregnancy (P1, P2, P3, P4, P5, P6, P7, P8, P9)
  - c. DK
  - d. RF
14. From {second trimester start date} until the end of your pregnancy, did you take any medications to manage your diabetes and its complications?
- a. YES → CONTINUE TO I5
  - b. NO → SKIP TO NEXT SECTION
  - c. DK → SKIP TO NEXT SECTION
  - d. RF → SKIP TO NEXT SECTION
15. What medications did you take? /Did you take anything else? LIST ALL. IF CAN'T RECALL, READ FROM DRUG LIST. Did you take...?
- a. Actos
  - b. Amaryl
  - c. Byetta
  - d. Diabeta
  - e. Diabinese
  - f. Glucophage
  - g. Glucotrol
  - h. Glucotrol XL
  - i. Glumetza
  - j. Glyburide
  - k. Glynase PresTab
  - l. Humalog
  - m. Humulin N
  - n. Humulin R
  - o. Januvia

- p. Lantus
- q. Levemir
- r. Metformin HCL
- s. Micronase
- t. Novolin N
- u. Novolin R
- v. Novolog
- w. Onglyza
- x. Prandin
- y. Precose
- z. Starlix
- aa. Victoza
- bb. OTHER (SPECIFY)
- cc. DK → SKIP TO NEXT SECTION
- dd. RF →SKIP TO NEXT SECTION

16. When did you start using {medication} for diabetes during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

17. When did you stop using {medication} during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO I6 AND I7, SKIP I8
- c. DK
- d. RF

18. Or, From {second trimester start date} until the end of your pregnancy, how long did you take it?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

- I9. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.
- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/ DK/RF
  - b. DK
  - c. RF
- I10. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?
- a. YES → RETURN TO H6, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO I11
  - b. NO → CONTINUE TO I11
- I11. Did you take anything else for diabetes?
- a. YES → RETURN TO I5
  - b. NO → CONTINUE TO NEXT SECTION

## Section J. HIGH BLOOD PRESSURE

IF THE PARTICIPANT DID NOT REPORT A DIAGNOSIS OF HYPERTENSION [PRIMARY CATI H28 = NO, DK, RF] → SKIP TO NEXT SECTION.

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF HYPERTENSION [PRIMARY CATI H28 = YES] → READ:

In the previous interview, you told us that you had been diagnosed with high blood pressure in the past. Now I would like to ask some additional questions about your high blood pressure and any medications that you took to treat it from the beginning of your second trimester, that is from {second trimester start date}, until the end of your pregnancy.

- J1. What type of high blood pressure did you or do you have? Was it **pregnancy-related** – that is during pregnancy only? Or is it **chronic high blood pressure or chronic hypertension**? This is high blood pressure that is not related to your pregnancy. This may have been diagnosed during pregnancy but did not go away after the pregnancy ended.
- a. Pregnancy related → CONTINUE TO J2
  - b. Chronic high blood pressure → SKIP TO J4
  - c. Both → CONTINUE TO J2
  - d. DK → SKIP TO J4

- e. RF → SKIP TO J4
- J2. When did you have pregnancy-related high blood pressure? [READ LIST, a-c]
- a. During a previous pregnancy only → IF J1 = BOTH → SKIP TO J4  
IF J1 = PREGNANCY-RELATED → SKIP TO NEXT SECTION
  - b. During this [index] pregnancy only → CONTINUE TO J3
  - c. During this [index] pregnancy and a previous pregnancy → CONTINUE TO J3
  - d. DK → SKIP TO J4
  - e. RF → SKIP TO J4
- J3. When was high blood pressure diagnosed during your [index] pregnancy?
- a. Date \_\_\_\_\_
  - b. Month of pregnancy (P1, P2, P3, P4, P5, P6, P7, P8, P9)
  - c. DK
  - d. RF
- J4. From {second trimester start date} until the end of your pregnancy, did you take any medications or remedies for high blood pressure?
- a. YES → CONTINUE TO J5
  - b. NO → SKIP TO NEXT SECTION
  - c. DK → SKIP TO NEXT SECTION
  - d. RF → SKIP TO NEXT SECTION
- J5. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:
- a. Accupril
  - b. Adalat
  - c. Altace
  - d. Amlodipine
  - e. Atenolol
  - f. Avapro
  - g. Benazepril HCL
  - h. Benicar
  - i. Calan
  - j. Capoten
  - k. Cardizem
  - l. Covera -HS

- m. Cozaar
- n. Diltiazem HCL
- o. Diovan
- p. Enalapril Maleate
- q. Hydralazine
- r. Hydrochlorothiazide
- s. Inderal
- t. Irbesartan
- u. Labetalol
- v. Lisinopril
- w. Losartan Potassium
- x. Lotensin
- y. Methyldopa
- z. Metoprolol
- aa. Microzide
- bb. Nifedipine
- cc. Normodyne
- dd. Norvasc
- ee. Olmesartan Medoxomil
- ff. Prinivil
- gg. Procardia
- hh. Propranolol
- ii. Quinapril HCL
- jj. Ramipril
- kk. Tenormin
- ll. Tiazac
- mm. Trandate
- nn. Valsartan
- oo. Vasotec
- pp. Verapamil
- qq. Verelan
- rr. Zestril
- ss. OTHER (SPECIFY): \_\_\_\_\_
- tt. DK → SKIP TO NEXT SECTION
- uu. RF → SKIP TO NEXT SECTION

J6. When did you start using {medication} for high blood pressure during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF



- J7. When did you stop using {medication} during this time period?
- a. \_\_\_/\_\_\_/\_\_\_ date [mm/dd/yyyy] or
  - b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO J6 and J7, SKIP J8
  - c. DK
  - d. RF
- J8. From {second trimester start date} until the end of your pregnancy, how long did you take it?
- a. AMOUNT: \_\_\_\_\_
    - i. Days
    - ii. Weeks
    - iii. Months
  - b. DK
  - c. RF
- J9. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.
- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF
- J10. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?
- a. YES → RETURN TO J6, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO J11
  - b. NO → CONTINUE TO J11
- J11. Did you take anything else for high blood pressure?
- a. YES → RETURN TO J5
  - b. NO → CONTINUE TO NEXT SECTION

## Section K. PREECLAMPSIA/ECLAMPSIA

- K1. Did a doctor or other healthcare professional tell you that you had toxemia, pre-eclampsia, or eclampsia at any time during your [index] pregnancy?

- a. YES → CONTINUE TO K2
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

K2. Which condition(s) did you have? [READ ALL, RECORD ALL]

- a. Toxemia/pre-eclampsia → When was it diagnosed (month of pregnancy) \_\_\_\_
- b. Eclampsia → When was it diagnosed (month of pregnancy) \_\_\_\_
- c. DK
- d. RF

K3. From {second trimester start date} until the end of your pregnancy, did you take any medications or remedies for {specific condition(s)}?

- a. YES → CONTINUE TO K4
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

K4. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

- a. Accupril
- b. Adalat
- c. Altace
- d. Amlodipine
- e. Atenolol
- f. Avapro
- g. Benazepril HCL
- h. Benicar
- i. Calan
- j. Capoten
- k. Cardizem
- l. Covera -HS
- m. Cozaar
- n. Diltiazem HCL
- o. Diovan
- p. Enalapril Maleate
- q. Hydralazine
- r. Hydrochlorothiazide
- s. Inderal

- t. Irbesartan
- u. Labetalol
- v. Lisinopril
- w. Losartan Potassium
- x. Lotensin
- y. Magnesium sulfate
- z. Methyldopa
- aa. Metoprolol
- bb. Microzide
- cc. Nicardipine
- dd. Nifedipine
- ee. Nitroprusside
- ff. Normodyne
- gg. Norvasc
- hh. Olmesartan Medoxomil
- ii. Prinivil
- jj. Procardia
- kk. Propranolol
- ll. Quinapril HCL
- mm. Ramipril
- nn. Steroid NOS
- oo. Tenormin
- pp. Tiazac
- qq. Trandate
- rr. Valsartan
- ss. Vasotec
- tt. Verapamil
- uu. Verelan
- vv. Zestril
- ww. OTHER (SPECIFY): \_\_\_\_\_
- xx. DK → SKIP TO NEXT SECTION
- yy. RF → SKIP TO NEXT SECTION

K5. When did you start using {medication} for {specific condition(s)} during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd/yyyy] or
- b. \_\_\_ MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

K6. When did you stop using {medication} during this time period?

- a. \_\_\_/\_\_\_/\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO K5 and K6, SKIP K7
- c. DK
- d. RF

K7. From {second trimester start date} until the end of your pregnancy, how long did you take it?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

K8. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF

K9. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?

- a. YES → RETURN TO K5, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO K10
- b. NO → CONTINUE TO K10

K10. Did you take anything else for {specific condition(s)}?

- a. YES → RETURN TO K4
- b. NO → CONTINUE TO NEXT SECTION

## Section L. EPILEPSY/SEIZURES

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF EPILEPSY [PRIMARY CATI K1 = NO, DK, RF OR K1 = YES AND K3 = AFTER THE PREGNANCY, DK, RF] → SKIP TO L11

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF EPILEPSY THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [PRIMARY CATI K1 = YES AND K3 = MORE THAN 2 YEARS BEFORE

(PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY] → READ:

In the previous interview, you told us that you had been diagnosed with epilepsy in the past. Now I would like to ask some questions specifically about your condition from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

L1. From {second trimester start date} until the end of your pregnancy, did you take any medications to treat your epilepsy?

- a. YES → CONTINUE TO L2
- b. NO → SKIP TO L9
- c. DK → SKIP TO L9
- d. RF → SKIP TO L9

L2. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

- a. Carbamazepine
- b. Carbatrol
- c. Clonazepam
- d. Depacon
- e. Depakene Capsules
- f. Depakote
- g. Dilantin
- h. Eptol
- i. Equetro
- j. Felbatol
- k. Keppra
- l. Klonopin
- m. Lamictal
- n. Lamotrigine
- o. Phenobarbital
- p. Phenytoin
- q. Stavzor
- r. Tegretol
- s. Topamax
- t. Topiramate
- u. Trileptal
- v. Valproic Acid
- w. OTHER (SPECIFY)
- x. DK → SKIP TO L9
- y. RF → SKIP TO L9

- L3. When did you start using {medication} for epilepsy during this time period?
- \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
  - MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
  - DK
  - RF
- L4. When did you stop using {medication} during this time period?
- \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
  - MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO L3 and L4, SKIP L5
  - DK
  - RF
- L5. From {second trimester start date} until the end of your pregnancy, how long did you take it?
- AMOUNT: \_\_\_\_\_
    - Days
    - Weeks
    - Months
  - DK
  - RF
- L6. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.
- AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/ DK /RF
- L7. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?
- YES → RETURN TO L3, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO L8
  - NO → CONTINUE TO L8
- L8. Did you take anything else for epilepsy?
- YES → RETURN TO L2
  - NO → CONTINUE TO L9

L9. From {second trimester start date} until the end of your pregnancy, did you have any seizures?

- a. YES → CONTINUE TO L10
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

L10. How many seizures did you have altogether during that time?

- a. AMOUNT:\_\_\_\_\_ → THEN SKIP TO NEXT SECTION
- b. DK → SKIP TO NEXT SECTION
- c. RF → SKIP TO NEXT SECTION

L11. At any time from the month before you became pregnant through the end of your pregnancy did you have any seizures?

- a. YES → CONTINUE TO L12
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

L12. How many seizures did you have altogether during that time?

- a. AMOUNT:\_\_\_\_\_
- b. DK
- c. RF

L13. At any time from the month before you became pregnant through the end of your pregnancy, did you take any medications to treat this condition or to prevent seizures?

- a. YES → CONTINUE TO L14
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

L14. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

- a. Carbamazepine
- b. Carbatrol
- c. Clonazepam
- d. Depacon
- e. Depakene Capsules
- f. Depakote
- g. Dilantin

- h. Epitol
- i. Equetro
- j. Felbatol
- k. Keppra
- l. Klonopin
- m. Lamictal
- n. Lamotrigine
- o. Phenobarbital
- p. Phenytoin
- q. Stavzor
- r. Tegretol
- s. Topamax
- t. Topiramate
- u. Trileptal
- v. Valproic Acid
- w. OTHER (SPECIFY)
- x. DK → SKIP TO NEXT SECTION
- y. RF → SKIP TO NEXT SECTION

L15. When did you start using {medication} for epilepsy during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (B1, P1, P2, P3, P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

L16. When did you stop using {medication} during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (B1, P1, P2, P3, P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO L15 and L16, SKIP L17
- c. DK
- d. RF

L17. How long did you take it during this time period?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF



L18. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF

L19. Did you use {medication} at any other time from the month before you became pregnant until the end of your pregnancy?

- a. YES → RETURN TO L15, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO L20
- b. NO → CONTINUE TO L20

L20. Did you take anything else for your condition?

- a. YES → RETURN TO L14
- b. NO → CONTINUE NEXT SECTION

## Section M. MIGRAINE

IF THE PARTICIPANT DID NOT REPORT MIGRAINES PREVIOUSLY [Primary CATI L1 = NO, DK, RF] → SKIP TO NEXT SECTION

IF THE PARTICIPANT REPORTED MIGRAINES PREVIOUSLY [Primary CATI L1 = YES] → READ:

In the previous interview, you told us that you have had migraines in the past. Now I would like to ask you some questions about your condition from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

M1. From {second trimester start date} until the end of your pregnancy, did you have any migraines?

- a. YES → CONTINUE TO M2
- b. NO → SKIP TO M3
- c. DK → SKIP TO M3
- d. RF → SKIP TO M3

M2. From {second trimester start date} until the end of your pregnancy, how many migraines did you have altogether?

- a. Total number: \_\_\_\_\_ / DK /RF or
- b. Frequency - AMOUNT: \_\_\_\_\_
  - i. Per day
  - ii. Per week
  - iii. Per month

- M3. Now I am going to ask about maintenance medications and remedies you may use for your migraines. Please include medications that you may use to keep from having or to prevent migraines AND medications that you may use to treat migraine pain when it happens. Please include over-the-counter medications and prescription medications.

From {second trimester start date} until the end of your pregnancy, did you take any medications or remedies for migraines?

- a. YES → CONTINUE TO M4
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

- M4. What did you take? / Did you take anything else? IF CAN'T RECALL: Was this a medication you used to prevent a migraine from starting or to treat pain from a migraine that already started? IF IT WAS PAIN MEDICATION: Was this over-the-counter or prescription? THEN READ FROM THE APPROPRIATE DRUG LIST:

PREVENTION MEDICATIONS

- a. Advil
- b. Aleve
- c. Amitriptyline
- d. Aspirin
- e. Atenolol
- f. Botox
- g. Calan
- h. Carbamazepine
- i. Carbatrol
- j. Cyproheptadine HCL
- k. Depacon
- l. Depakene
- m. Depakote
- n. Diltiazem
- o. Divalproex Sodium
- p. Doxepin
- q. Effexor
- r. Epitol
- s. Equetro
- t. Excedrin Extra Strength Caplets/Tablets/Geltabs
- u. Gabapentin
- v. Ibuprofen

- w. Inderal
- x. Innopran XL
- y. Lamictal
- z. Lamotrigine
- aa. Lisinopril
- bb. Metoprolol
- cc. Motrin
- dd. Motrin Ib
- ee. Nadolol
- ff. Naproxen Sodium
- gg. Neurontin
- hh. Nifedipine
- ii. Nimodipine
- jj. Nortriptyline
- kk. Pamelor
- ll. Propranolol
- mm. Protriptyline HCL
- nn. Tegretol
- oo. Timolol
- pp. Topamax
- qq. Topiramate
- rr. Valproate Sodium
- ss. Valproic Acid
- tt. Venlafaxine
- uu. Verapamil
- vv. Verelan
- ww. Vivactil
- xx. Zestril

#### OVER-THE-COUNTER PAIN MEDICATIONS

- yy. Acetaminophen
- zz. Advil
- aaa. Aleve
- bbb. Aspirin
- ccc. Excedrin Migraine
- ddd. Ibuprofen
- eee. Motrin
- fff. Naproxen Sodium
- ggg. Tylenol

#### PRESCRIPTION PAIN MEDICATIONS

- hhh. Acetaminophen with Codeine
- iii. Almotriptan Maleate
- jjj. Amerge
- kkk. Axert
- lll. Cafegot
- mmm. Dihydroergotamine
- nnn. Eletriptan Hydrobromide
- ooo. Ergotamine
- ppp. Fioricet
- qqq. Frova
- rrr. Frovatriptan Succinate
- sss. Imitrex
- ttt. Indomethacin
- uuu. Maxalt
- vvv. Migergot Suppositories
- www. Migranal
- xxx. Naproxen Sodium / Sumatriptan Succinate
- yyy. Naratriptan
- zzz. Relpax
- aaaa. Rizatriptan
- bbbb. Sumatriptan Succinate
- cccc. Treximet
- dddd. Zolmitriptan
- eeee. Zomig
- ffff. OTHER (SPECIFY): \_\_\_\_\_
- gggg. DK → SKIP TO NEXT SECTION
- hhhh. RF → SKIP TO NEXT SECTION

M5. When did you start using {medication} for migraines during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd /yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

M6. When did you stop using {medication} during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd /yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO M5 and M6, SKIP M7
- c. DK
- d. RF

M7. From {second trimester start date} until the end of your pregnancy, how long did you take it?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

M8. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF

M9. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?

- a. YES → RETURN TO M5, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO M10
- b. NO → CONTINUE TO M10

M10. Did you take anything else for migraines?

- a. YES → RETURN TO M4
- b. NO → CONTINUE TO NEXT SECTION

## Section N. DEPRESSION / ANXIETY

IF THE PARTICIPANT DID NOT REPORT A DIAGNOSIS OF ANXIETY OR DEPRESSION BEFORE THE END OF THE INDEX PREGNANCY

[PRIMARY CATI O1 = NO, DK, RF AND O4= NO, DK, RF

OR

PRIMARY CATI O1 = NO, DK, RF AND O4 = YES AND O5= AFTER THE PREGNANCY

OR

PRIMARY CATI O1= YES AND O3 = AFTER THE PREGNANCY AND O4= NO, DK, RF

OR

PRIMARY CATI O1= YES AND O3 = AFTER THE PREGNANCY AND O4 = YES AND O5= AFTER THE PREGNANCY]

→SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF ANXIETY OR DEPRESSION THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [PRIMARY CATI O1 = YES AND O3 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY AND/ OR O4 =YES AND O5= MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY]  
→ READ:

In the previous interview, you told us that you were diagnosed in the past *with depression* [IF PRIMARY CATI O4 = YES] / *{anxiety condition from O2}* [IF O1 = YES]. Now I would like to ask you about your condition from the beginning of your second trimester, *{second trimester start date}*, until the end of your pregnancy.

N1. Did you experience any symptoms from *{second trimester start date}*, until the end of your pregnancy?

- a. YES → CONTINUE TO N2
- b. NO → SKIP TO N3
- c. DK → SKIP TO N3
- d. RF → SKIP TO N3

N2. What were the symptoms you experienced?

- a. Specify: \_\_\_\_\_ /DK /RF

N3. From *{second trimester start date}* until the end of your pregnancy, did you use any medications to treat your condition?

- a. YES → CONTINUE TO N4
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

N4. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST

- a. Abilify
- b. Alprazolam
- c. Anafranil
- d. Aripiprazole
- e. Ativan
- f. Bupropion
- g. Buspar

- h. Buspirone HCL
- i. Carbamazepine
- j. Carbatrol
- k. Celexa
- l. Citalopram Hydrobromide
- m. Clomipramine
- n. Clonazepam
- o. Cymbalta
- p. Depacon
- q. Depakene
- r. Depakote
- s. Diazepam
- t. Duloxetine HCL
- u. Effexor
- v. Epitol
- w. Equetro
- x. Escitalopram Oxolate
- y. Fluoxetine HCL
- z. Imipramine
- aa. Inderal
- bb. Klonopin
- cc. Lamictal
- dd. Lamotrigine
- ee. Lexapro
- ff. Lorazepam
- gg. Paroxetine HCL
- hh. Paxil
- ii. Propranolol
- jj. Prozac
- kk. Sertraline HCL
- ll. St. John's Wort
- mm. Tegretol
- nn. Tofranil
- oo. Valium
- pp. Valproic acid
- qq. Venlafaxine
- rr. Wellbutrin
- ss. Xanax
- tt. Zoloft
- uu. OTHER (SPECIFY):\_\_\_\_\_
- vv. DK → SKIP TO NEXT SECTION
- ww. RF → SKIP TO NEXT SECTION

N5. When did you start using {medication} for your condition during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

N6. When did you stop using {medication} during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO N5 AND N6, SKIP N7
- c. DK
- d. RF

N7. From {second trimester start date} until the end of your pregnancy, how long did you take it?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

N8. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF

N9. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?

- a. YES → RETURN TO N5, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO N10
- b. NO → CONTINUE TO N10

N10. Did you take anything else for this condition?

- a. YES → RETURN TO N4
- b. NO → CONTINUE TO NEXT SECTION



## Section O. BLEEDING/CLOTTING DISORDERS

- O1. Did a doctor or other healthcare provider ever tell you that had a bleeding disorder or a clotting disorder?
- a. YES → CONTINUE TO O2
  - b. NO → SKIP TO O7
  - c. DK → SKIP TO O7
  - d. RF → SKIP TO O7
- O2. What was the name of the bleeding or clotting disorder?
- a. \_\_\_\_\_ (specify)
  - b. DK
  - c. RF
- O3. When were you diagnosed with this condition?
- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or \_\_\_\_\_ (Age in years)
  - b. DK
  - c. RF
- O4. At any time during your pregnancy, did you have any complications from this condition, for example, significant bleeding or a blood clot?
- a. YES → CONTINUE TO O5
  - b. NO → SKIP TO O7
  - c. DK → SKIP TO O7
  - d. RF → SKIP TO O7
- O5. What were the complications?
- a. \_\_\_\_\_ (specify)
  - b. DK
  - c. RF
- O6. When did it occur? Any other times?
- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] OR
  - b. \_\_\_ MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
  - c. DK
  - d. RF

O7. At any time during your pregnancy, did you take any medications or receive any treatments for a bleeding or clotting disorder? Please include anything you may have taken to prevent a problem.

- e. YES → CONTINUE TO O8
- f. NO → SKIP TO NEXT SECTION
- g. DK → SKIP TO NEXT SECTION
- h. RF → SKIP TO NEXT SECTION

O8. What did you take? / Did you take anything else?

- a. SPECIFY: \_\_\_\_\_
- b. DK → SKIP TO NEXT SECTION
- c. RF → SKIP TO NEXT SECTION

O9. When did you start using {medication} for your condition during your pregnancy?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P1, P2, P3, P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

O10. When did you stop using {medication}?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P1, P2, P3, P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO O9 and O10, SKIP O11
- c. DK
- d. RF

O11. How long did you take it during your pregnancy?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

O12. How often did you take {medication} during your pregnancy? You can say the number of times per day, per week, or per month.

- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF

- O13. Did you use {medication} at any other time during your pregnancy?
- YES → RETURN TO O9, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO O14
  - NO → CONTINUE TO O14
- O14. Did you take anything else for this condition?
- YES → RETURN TO O8
  - NO → CONTINUE TO NEXT SECTION

## Section P. AUTOIMMUNE DISEASE

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF AN AUTOIMMUNE DISEASE [PRIMARY CATI M1 = NONE, DK, RF OR M1 = YES AND M2 = AFTER THE PREGNANCY] → SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF AN AUTOIMMUNE DISEASE THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [PRIMARY CATI M1 = YES AND M2 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY] → READ:

In the previous interview, you told us that you were diagnosed in the past with {specific condition(s) from M1}. Now I would like to ask you about your condition(s) from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

ASK THESE QUESTIONS FOR EACH CONDITION GIVEN IN PRIMARY CATI M1

- P1. From {second trimester start date} until the end of your pregnancy, did you take any medications to treat {specific condition}?
- YES → CONTINUE TO P2
  - NO → SKIP TO NEXT CONDITION OR IF NONE, TO NEXT SECTION
  - DK → SKIP TO NEXT CONDITION OR IF NONE, TO NEXT SECTION
  - RF → SKIP TO NEXT CONDITION OR IF NONE, TO NEXT SECTION
- P2. What did you take? / Did you take anything else? SPECIFY: \_\_\_\_\_  
IF CAN'T RECALL, READ FROM DRUG PROMPT LISTS FOR THESE 4 CONDITIONS, BUT DRUGS ASKED FOR EACH CONDITION.

**P2a. Lupus:**

- a. Advil
- b. Aleve
- c. Arava
- d. Azasan
- e. Azathioprine
- f. Belimumab
- g. Benlysta
- h. Cellcept
- i. Cyclophosphamide
- j. Cytoxan
- k. Hydroxychloroquine Sulfate
- l. Leflunomide
- m. Methotrexate
- n. Motrin
- o. Mycophenolate Mofetil
- p. Plaquenil
- q. Prednisone
- r. Trexall
- s. OTHER, SPECIFY: \_\_\_\_\_
- t. DK → SKIP TO NEXT CONDITION/NEXT SECTION
- u. RF → SKIP TO NEXT CONDITION/NEXT SECTION

**P2b. Rheumatoid arthritis:**

- a. Abatacept
- b. Actemra
- c. Adalimumab
- d. Advil
- e. Aleve
- f. Anakinra
- g. Arava
- h. Azasan
- i. Azathioprine
- j. Azulfidine
- k. Certolizumab Pegol
- l. Cimzia
- m. Cyclophosphamide
- n. Cyclosporine
- o. Cytoxan
- p. Dynacin
- q. Enbrel

- r. Etanercept
- s. Gengraf
- t. Golimumab
- u. Humira
- v. Hydroxychloroquine Sulfate
- w. Ibuprofen
- x. Imuran
- y. Infliximab
- z. Kineret
- aa. Leflunomide
- bb. Methotrexate
- cc. Minocin
- dd. Minocycline
- ee. Motrin
- ff. Naproxen Sodium
- gg. Neoral
- hh. Orencia
- ii. Plaquenil
- jj. Prednisone
- kk. Remicade
- ll. Rituxan
- mm. Rituximab
- nn. Sandimmune
- oo. Simponi
- pp. Sulfasalazine
- qq. Tocilizumab
- rr. Trexall
- ss. OTHER, SPECIFY: \_\_\_\_\_
- tt. DK → SKIP TO NEXT CONDITION/NEXT SECTION
- uu. RF → SKIP TO NEXT CONDITION/NEXT SECTION

**P2c. Multiple sclerosis:**

- a. Amantadine
- b. Ampyra
- c. Amrix
- d. Aubagio
- e. Avonex
- f. Baclofen
- g. Betaseron
- h. Copaxone
- i. Cyclobenzaprine
- j. Dalfampridine

- k. Extavia
- l. Fingolimod
- m. Flexeril
- n. Gilenya
- o. Glatiramer Acetate
- p. Lioresal
- q. Methylprednisolone
- r. Mitoxantrone HCL
- s. Natalizumab
- t. Prednisone
- u. Rebif
- v. Solu-Medrol
- w. Tecfidera
- x. Teriflunomide
- y. Tizanidine HCL
- z. Tysabri
- aa. Zanaflex
- bb. OTHER, SPECIFY: \_\_\_\_\_
- cc. DK → SKIP TO NEXT CONDITION/NEXT SECTION
- dd. RF → SKIP TO NEXT CONDITION/NEXT SECTION

**P2d. Crohn's disease and ulcerative colitis:**

- a. Adalimumab
- b. Apriso
- c. Asacol
- d. Azasan
- e. Azathioprine
- f. Azulfidine
- g. Balsalazide Disodium
- h. Certolizumab Pegol
- i. Cimzia
- j. Cipro
- k. Ciprofloxacin HCL
- l. Colazal
- m. Cyclosporine
- n. Dipentum
- o. Flagyl
- p. Gengraf
- q. Humira
- r. Imuran
- s. Infliximab
- t. Lialda

- u. Mercaptopurine
- v. Mesalamine
- w. Methotrexate
- x. Metronidazole
- y. Natalizumab
- z. Neoral
- aa. Olsalazine Sodium
- bb. Purinethol
- cc. Remicade
- dd. Rheumatrex
- ee. Sandimmune
- ff. Sulfasalazine
- gg. Tysabri
- hh. OTHER (SPECIFY): \_\_\_\_\_
- ii. DK → SKIP TO NEXT CONDITION/NEXT SECTION
- jj. RF → SKIP TO NEXT CONDITION/NEXT SECTION

**P2e. Psoriasis:**

- a. Anthralin
- b. Calcipotriene
- c. Coal Tar
- d. Dovonex
- e. Elidel
- f. Protopic Ointment
- g. Retin-A
- h. Salicylic Acid
- i. Tazorac
- j. Tazarotene
- k. Tretinoin
- l. OTHER (SPECIFY): \_\_\_\_\_
- m. DK → SKIP TO NEXT CONDITION/NEXT SECTION
- n. RF → SKIP TO NEXT CONDITION/NEXT SECTION

P3. When did you start using {medication} for {specific condition} during this time period?

- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

P4. When did you stop using {medication} during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO P3 AND P4, SKIP P5
- c. DK
- d. RF

P5. From {second trimester start date} until the end of your pregnancy, how long did you take it?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

P6. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/DK/RF

P7. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?

- a. YES → RETURN TO P3, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO P8
- b. NO → CONTINUE TO P8

P8. Did you take anything else for this condition?

- a. YES → RETURN TO P2
- b. NO → CONTINUE TO NEXT CONDITION OR IF NONE, TO NEXT SECTION

## Section Q. FEVER

Q1. From the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy, did you have any fevers, including those due to respiratory illness, bronchitis, pneumonia, a kidney, bladder, or urinary tract infection, pelvic inflammatory disease, or other infections or illness?

- a. YES → CONTINUE TO Q2
- b. NO → SKIP TO NEXT SECTION



- c. DK → SKIP TO NEXT SECTION
  - d. RF → SKIP TO NEXT SECTION
- Q2. From {second trimester start date} until the end of your pregnancy, how many fevers do you remember having? IF DK NUMBER, SELECT 1 AND ASK MOM FOR DETAILS ABOUT 1 FEVER SHE REMEMBERS.
- a. NUMBER: \_\_\_\_\_
  - b. DK
  - c. RF
- Q3. What was the cause of the {first, then second, etc.} fever?
- a. CAUSE: \_\_\_\_\_
  - b. DK
  - c. RF
- Q4. When you had {cause}, during which of those months did you have a fever?
- a. P4
  - b. P5
  - c. P6
  - d. P7
  - e. P8
  - f. P9
  - g. DK
  - h. RF
- Q5. What was the highest temperature recorded during your fever?
- a. VALUE: \_\_\_\_\_
    - i. UNITS: F or C \_\_\_\_\_
  - b. DK
  - c. RF
- Q6. Did you take any medications or remedies for this fever?
- a. YES → CONTINUE TO Q7
  - b. NO → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED → SKIP TO NEXT SECTION
  - c. DK → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION
  - d. RF → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION

- Q7. What did you take? Did you take anything else? CODE ALL THAT APPLY. IF CAN'T RECALL, READ FROM DRUG LIST: Did you take...?
- a. Acetaminophen
  - b. Advil
  - c. Aleve
  - d. Ibuprofen
  - e. Motrin
  - f. Naproxen sodium
  - g. Nuprin
  - h. Tylenol
  - i. OTHER (SPECIFY): \_\_\_\_\_
  - j. DK → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION
  - k. RF → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION
- Q8. When did you start using {medication} for this fever?
- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
  - b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
  - c. DK
  - d. RF
- Q9. When did you stop using {medication} for this fever?
- a. \_\_\_ / \_\_\_ / \_\_\_ date [mm/dd /yyyy] or
  - b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO Q8 and Q9, SKIP Q10
  - c. DK
  - d. RF
- Q10. How long did you take it for this fever?
- a. AMOUNT: \_\_\_\_\_
    - i. Days
    - ii. Weeks
    - iii. Months
  - b. DK
  - c. RF
- Q11. How often did you use {medication} for this fever? You can say the number of times per day, per week, or per month.

a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/Per Time Period/DK/RF

Q12. Did you use {medication} for the fever you had with {cause} at any other time from {second trimester start date} until the end of your pregnancy?

- a. YES → RETURN TO Q8, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO Q13
- b. NO → CONTINUE TO Q13

Q13. Did you take anything else for the fever you had with {cause}?

- a. YES → RETURN TO Q7
- b. NO → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER

WHEN ALL FEVER EPISODES HAVE BEEN COVERED → CONTINUE TO NEXT SECTION

## Section R. ASTHMA

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF ASTHMA [PRIMARY CATI J1 = NO, DK, RF OR J1 = YES AND J2 = AFTER THE PREGNANCY] → SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF ASTHMA THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [PRIMARY CATI J1 = YES AND J2 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY] → READ:

In the previous interview, you told us that you were diagnosed in the past with asthma. Now I would like to ask you some additional questions about your asthma. In these questions, I am referring to your pregnancy with {name of infant} (for liveborns)/ that ended on {pregnancy end date} (for stillbirths).

R1. At any time **during the year before you became pregnant . . .**

R1a. Were you hospitalized overnight because of your asthma?

- a. YES → CONTINUE TO R1b
- b. NO → SKIP TO R1c
- c. DK → SKIP TO R1c
- d. RF → SKIP TO R1c

R1b. When were you hospitalized?

a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/ dd /yyyy → THEN ASK: Any other times?

R1c. Did you go to an emergency room for increased asthma symptoms (but did not require hospitalization)?

- a. YES → CONTINUE TO R1d
- b. NO → SKIP TO R1e
- c. DK → SKIP TO R1e
- d. RF → SKIP TO R1e

R1d. When did you go to an emergency room?

a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/ dd /yyyy → THEN ASK: Any other times?

R1e. Did you have to make an urgent visit to a physician or clinic for increased asthma symptoms (other than the above)?

- a. YES → CONTINUE TO R1f
- b. NO → SKIP TO R1g
- c. DK → SKIP TO R1g
- d. RF → SKIP TO R1g

R1f. When did you make the urgent visit?

a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/ dd /yyyy → THEN ASK: Any other times?

R1g. Were you given steroids (ex. Prednisone) as tablet, injection or IV?

- a. YES → CONTINUE TO R1h
- b. NO → SKIP TO R2
- c. DK → SKIP TO R2
- d. RF → SKIP TO R2

R1h. When were you given steroids?

a. \_\_\_\_\_ Date → THEN ASK: Any other times?

R2. And now some more questions about **the year before you became pregnant.**

R2a. How much of the time did your asthma interfere with getting your work done at home or on the job?

- a. NEVER
- b. SOMETIMES
- c. OFTEN
- d. CONSTANTLY

R2b. How often did you have shortness of breath due to your asthma?

- a. \_\_\_\_\_ Number of times per day or per period

R2c. How often did your asthma wake you up at night or earlier than usual in the morning?

- a. \_\_\_\_\_ Number of times per day or per period

R2d. How often did you use an inhaler for immediate relief of asthma symptoms?

- a. \_\_\_\_\_ Number of times per day or per period

R2e. How would you rate your asthma control?

- a. COMPLETELY CONTROLLED
- b. WELL CONTROLLED
- c. SOMEWHAT CONTROLLED
- d. POORLY CONTROLLED
- e. NOT AT ALL CONTROLLED

R3. The next questions are about your asthma **during your pregnancy**. At any time **during your pregnancy** . . .

R3a. Were you hospitalized overnight because of your asthma?

- a. YES → CONTINUE TO R3b
- b. NO → SKIP TO R3c
- c. DK → SKIP TO R3c
- d. RF → SKIP TO R3c

R3b. When were you hospitalized?

- a. \_\_\_\_\_ Date → THEN ASK: Any other times?

R3c. Did you go to an emergency room for increased asthma symptoms (but did not require hospitalization)?

- a. YES → CONTINUE TO R3d

- b. NO → SKIP TO R3e
- c. DK → SKIP TO R3e
- d. RF → SKIP TO R3e

R3d. When did you go to an emergency room?

- a. \_\_\_\_\_ Date → THEN ASK: Any other times?

R3e. Did you have to make an urgent visit to a physician or clinic for increased asthma symptoms (other than the above)?

- a. YES → CONTINUE TO R3f
- b. NO → SKIP TO R3g
- c. DK → SKIP TO R3g
- d. RF → SKIP TO R3g

R3f. When did you make the urgent visit?

- a. \_\_\_\_\_ Date → THEN ASK: Any other times?

R3g. Were you given steroids (ex. Prednisone) as tablet, injection or IV?

- a. YES → CONTINUE TO R3h
- b. NO → SKIP TO R4
- c. DK → SKIP TO R4
- d. RF → SKIP TO R4

R3h. When were you given steroids?

- a. \_\_\_\_\_ Date → THEN ASK: Any other times?

R4. The next questions are about your asthma during the **first trimester** of your pregnancy. During **the first trimester of your pregnancy** . . .

R4a. How much of the time did your asthma interfere with getting your work done at home or on the job?

- a. NEVER
- b. SOMETIMES
- c. OFTEN
- d. CONSTANTLY

- R4b. How often did you have shortness of breath due to your asthma?
- a. \_\_\_\_\_ Number of times per day or per period
- R4c. How often did your asthma wake you up at night or earlier than usual in the morning?  
Again, we want to know about the first trimester of your pregnancy.
- a. \_\_\_\_\_ Number of times per day or per period
- R4d. How often did you use an inhaler for immediate relief of asthma symptoms?
- a. \_\_\_\_\_ Number of times per day or per period
- R4e. How would you rate your asthma control? Again, we want to know about the first trimester of your pregnancy.
- a. COMPLETELY CONTROLLED  
b. WELL CONTROLLED  
c. SOMEWHAT CONTROLLED  
d. POORLY CONTROLLED  
e. NOT AT ALL CONTROLLED
- R5. Next we'd like to ask about your asthma from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy. **During that time period . . .**
- R5a. How much of the time did your asthma interfere with getting your work done at home or on the job?
- a. NEVER  
b. SOMETIMES  
c. OFTEN  
d. CONSTANTLY
- R5b. How often did you have shortness of breath due to your asthma?
- a. \_\_\_\_\_ Number of times per day or per period
- R5c. How often did your asthma wake you up at night or earlier than usual in the morning?  
Again, now we want to know about the time from the beginning of your second trimester until the end of your pregnancy.
- a. \_\_\_\_\_ Number of times per day or per period

R5d. How often did you use an inhaler for immediate relief of asthma symptoms?

a. \_\_\_\_\_ Number of times per day or per period

R5e. How would you rate your asthma control? Again, now we want to know about the time from the beginning of your second trimester until the end of your pregnancy.

- a. COMPLETELY CONTROLLED
- b. WELL CONTROLLED
- c. SOMEWHAT CONTROLLED
- d. POORLY CONTROLLED
- e. NOT AT ALL CONTROLLED

R6. Finally, from {second trimester start date} until the end of your pregnancy, did you take any medications for your asthma? Please tell me about maintenance medications and remedies you may take for long-term control of your asthma and fast-acting, or “rescue”, medications you may take for treatment of an asthma attack.

- a. YES → CONTINUE to R7
- b. NO → SKIP TO NEXT SECTION

R7. What did you take? / Did you take anything else?

**NASAL SPRAYS**

- a. Flonase
- b. Flunisolide
- c. Fluticasone Nasal Spray
- d. Nasonex Nasal Spray
- e. Omnaris Nasal Spray
- f. Qnasl Nasal Aerosol
- g. Rhinocort
- h. OTHER (SPECIFY): \_\_\_\_\_

**ORAL INHALANTS**

- i. Advair
- j. Aerobid
- k. Aerospan Hfa
- l. Alvesco Inhaler
- m. Asmanex Twisthaler
- n. Budesonide Inhalation Suspension



- o. Dulera
- p. Flovent
- q. Foradil
- r. Formoterol Fumarate
- s. Perforomist
- t. Pulmicort
- u. Qvar HFA Inhaler
- v. Salmeterol Xinafoate
- w. Serevent
- x. Symbicort
- y. OTHER (SPECIFY):\_\_\_\_\_

**ORAL TABLETS/CAPS**

- z. Accolate
- aa. Montelukast Sodium
- bb. Singulair
- cc. Zafirlukast
- dd. Zileuton
- ee. Zyflo
- ff. OTHER (SPECIFY):\_\_\_\_\_

**FAST ACTING OR "RESCUE" MEDICATIONS**

- gg. Albuterol
- hh. Asthmanefrin
- ii. Atrovent HFA
- jj. Ipratropium Bromide
- kk. Levalbuterol Tartrate
- ll. Maxair
- mm. Pirbuterol Acetate
- nn. ProAir HFA Inhaler
- oo. Ventolin HFA
- pp. Xopenex HFA
- qq. OTHER (SPECIFY):\_\_\_\_\_

**DON'T KNOW/REFUSED**

- rr. DK → SKIP TO NEXT SECTION
- ss. RF → SKIP TO NEXT SECTION

R8. When did you start using {medication} for asthma during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
- c. DK
- d. RF

R9. When did you stop using {medication} during this time period?

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] or
- b. MONTH OF PREGNANCY ((P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO R8 and R9, SKIP R10
- c. DK
- d. RF

R10. From {second trimester start date} until the end of your pregnancy, how long did you take it?

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

R11. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

- a. AMOUNT: \_\_\_\_\_ Per Day/Per Week/Per Month/ DK /RF

R12. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?

- a. YES → RETURN TO R8, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO R13
- b. NO → CONTINUE TO R13

R13. Did you take anything else for this condition?

- a. YES → RETURN TO R7
- b. NO → CONTINUE TO NEXT SECTION

## Section S. INJURY

S1. From the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy, did you have physical harm to your body due to injury, abuse, or crime?

- a. YES → CONTINUE TO S2
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

S2. Did you seek medical care for this injury?

- a. YES → CONTINUE TO S3
- b. NO → SKIP TO NEXT SECTION
- c. DK → SKIP TO NEXT SECTION
- d. RF → SKIP TO NEXT SECTION

S3. Were you hospitalized?

- a. YES
- b. NO
- c. DK
- d. RF

## Section T. SPECIFIC MEDICATION EXPOSURES

T1. Now I'm going to read you a list of specific medications. You may have already told me about some of these medications in the earlier questions, so please remind me if I repeat something. Please let me know if you have taken any of these medications from {second trimester start date} until the end of your pregnancy.

T1a. Pre-natal vitamins → If YES,

T1a1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1a2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR

- c. \_\_\_ Trimester
- d. DK
- e. RF

T1a3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1b. Folic acid → If YES,

T1b1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- f. DK
- g. RF

T1b2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1b3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1c. Alka-seltzer → If YES

T1c1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR

- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- h. DK
- i. RF

T1c2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1c3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1d. Pepto bismol → If YES,

T1d1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- j. DK
- k. RF

T1d2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1d3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days

- ii. Weeks
- iii. Months
- b. DK
- c. RF

T1e. Aspirin → If YES

T1e1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- l. DK
- m. RF

T1e2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1e3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1f. Aleve/Naprosyn/naproxen → If YES

T1f1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- n. DK
- o. RF

T1f2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR

- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1f3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1g. Advil/Motrin/ibuprofen → If YES

T1g1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- p. DK
- q. RF

T1g2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1g3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1h. Tylenol/acetaminophen

T1h1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- r. DK
- s. RF

T1h2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1h3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1i. Sudafed/pseudoephedrine → If YES

T1i1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- t. DK
- u. RF

T1i2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1i3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_



- i. Days
- ii. Weeks
- iii. Months
- b. DK
- c. RF

T1j. Afrin/oxymetazoline → If YES

T1j1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- v. DK
- w. RF

T1j2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1j3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1k. Neosynephrine/phenylephrine → If YES

T1k1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- x. DK
- y. RF

T1k2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1k3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1l. Adderall → If YES

T1l1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- z. DK
- aa. RF

T1l2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1l3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1m. Concerta/Ritalin/methylphenidate → If YES

- T1m1. Start date:
- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
  - b. \_\_\_ Months OR
  - c. \_\_\_ Trimester
  - bb. DK
  - cc. RF

- T1m2. Stop date:
- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
  - b. \_\_\_ Months OR
  - c. \_\_\_ Trimester
  - d. DK
  - e. RF

- T1m3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)
- a. AMOUNT: \_\_\_\_\_
    - i. Days
    - ii. Weeks
    - iii. Months
  - b. DK
  - c. RF

T1n. Stattera/atomoxetine → If YES

- T1n1. Start date:
- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
  - b. \_\_\_ Months OR
  - c. \_\_\_ Trimester
  - dd. DK
  - ee. RF

- T1n2. Stop date:
- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
  - b. \_\_\_ Months OR
  - c. \_\_\_ Trimester
  - d. DK
  - e. RF

T1n3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1o. Vyvanse/lisdexamfetamine → If YES

T1o1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- ff. DK
- gg. RF

T1o2. Stop date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1o3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1p. Amphetamines, methamphetamine, cocaine, crack? → If YES

T1p1. Start date:

- a. \_\_\_/\_\_\_/\_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- hh. DK
- ii. RF

T1p2. Stop date:

- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1p3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

T1q. Any other medications used in this time period? → If YES, specify all:

T1q1. Start date:

- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- jj. DK
- kk. RF

T1q2. Stop date:

- a. \_\_\_ / \_\_\_ / \_\_\_\_\_ date [mm/dd/yyyy] OR
- b. \_\_\_ Months OR
- c. \_\_\_ Trimester
- d. DK
- e. RF

T1q3. How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

- a. AMOUNT: \_\_\_\_\_
  - i. Days
  - ii. Weeks
  - iii. Months
- b. DK
- c. RF

## Section U: OTHER QUESTIONS

U1. Do you have any thoughts or ideas about what may cause stillbirths? [ASK OPEN-ENDED]

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### FINAL REMARK

In closing, we would like to sincerely thank you for your time and efforts. Your contribution to this important study will help us greatly in our work to better understand the causes of poor pregnancy outcomes. Thank you!