Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

Appendix 2. Chart Extraction

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Microcephaly Case Control Investigation	Infant case ID: ________-A-2 Date of extraction:__ __/ __ __/ __ __ __ __ day month year	Name of healthcare facility:______________ Town/City: __________________________ Municipality: _________________________

Infant History				**Pregnancy History (if noted)**		
Infant Date of Birth (d/m/y)	__ __/ __ __/ __ __ __ __			Mother Date of Birth (d/m/y)	__ __/ __ __/ __ __ __ __	
Date microcephaly diagnosed (d/m/y)	__ __/ __ __/ __ __ __ __			Total number of previous	___ Live births	
Sex: ☐ Male	☐ Female	☐ Ambiguous		____ Still births	____ Spontaneous abortions	
Gestational age at birth	_______(in weeks)					
Birth weight:	____________(in grams)			Are the parents related?	☐ Yes	☐ No
Birth length:	____________(in cm)			If yes, explain:______________________		
Birth head circumference	____________(in cm)					
Date (d/m/y) and time (hh:mm) of measurements	__ __/ __ __/ __ __ __ __ __ __: __ __			**Prenatal testing and history**		
Multiple birth:	☐ Yes	☐ No		Prenatal ultrasound	☐ Yes	☐ No
If yes, specify: ___________________________________				Results: ☐ Normal ☐ Abnormal; describe:_____________ ____		
				Prenatal amnio	☐ Yes	☐ No
				Results: ☐ Normal ☐ Abnormal; describe:_____________ ____		
Medical problems				Chorionic villus sampling	☐ Yes	☐ No
☐ Hearing problems ☐ Seizures ☐ Sepsis	☐ Blindness ☐ Difficulty swallowing ☐ Respiratory distress			Results: ☐ Normal ☐ Abnormal; describe:_____________ ____		
☐ Other, describe: ___________________________________ ____ ____				Underlying medical conditions during this pregnancy: ____ ____		
Imaging and test results for infant				Any complications with this pregnancy: ____ ____		
Neuroimaging performed:	☐ Yes	☐ No				
Record results noting scan type: ________________________ ____ ____				Maternal medications during this pregnancy: ____ ____		
Genetic testing performed:	☐ Yes	☐ No				
Record results noting test type: _________________________ ____ ____				Any noted maternal exposures (e.g., toxins, chemicals): ____ ____		
Infectious disease testing for infant				**Infectious disease testing performed during this pregnancy**		

VDRL		☐ Yes	☐ No	VDRL		☐ Yes	☐ No
	Is yes	☐ Reactive	☐ NR		Is yes	☐ Reactive	☐ NR
CMV		☐ Yes	☐ No	CMV		☐ Yes	☐ No
	If yes	☐ Positive IgM	☐ Negative IgM		If yes	☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
		☐ Positive cx	☐ Negative cx			☐ Positive cx	☐ Negative cx
HSV 1		☐ Yes	☐ No	HSV 1		☐ Yes	☐ No
	If yes	☐ Positive IgM	☐ Negative IgM		If yes	☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
		☐ Positive cx	☐ Negative cx			☐ Positive cx	☐ Negative cx
HSV 2		☐ Yes	☐ No	HSV 2		☐ Yes	☐ No
	If yes	☐ Positive IgM	☐ Negative IgM		If yes	☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
		☐ Positive cx	☐ Negative cx			☐ Positive cx	☐ Negative cx
Rubella		☐ Yes	☐ No	Rubella		☐ Yes	☐ No
	If yes	☐ Positive IgM	☐ Negative IgM		If yes	☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
Toxoplasmosis		☐ Yes	☐ No	Toxoplasmosis		☐ Yes	☐ No
		☐ Positive	☐ Negative			☐ Positive	☐ Negative
Dengue		☐ Yes	☐ No	Dengue		☐ Yes	☐ No
	If yes	☐ Positive RNA	☐ Negative RNA		If yes	☐ Positive RNA	☐ Negative RNA
		☐ Positive IgM	☐ Negative IgM			☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
Zika		☐ Yes	☐ No	Zika		☐ Yes	☐ No
	If yes	☐ Positive RNA	☐ Negative RNA		If yes	☐ Positive RNA	☐ Negative RNA
		☐ Positive IgM	☐ Negative IgM			☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
Chikungunya		☐ Yes	☐ No	Chikungunya		☐ Yes	☐ No
	If yes	☐ Positive RNA	☐ Negative RNA		If yes	☐ Positive RNA	☐ Negative RNA
		☐ Positive IgM	☐ Negative IgM			☐ Positive IgM	☐ Negative IgM
		☐ Positive IgG	☐ Negative IgG			☐ Positive IgG	☐ Negative IgG
Other 1:__________ _________________		☐ Yes	☐ No	Other 1:__________ ________________		☐ Yes	☐ No
Results: ____				Results: ____			
Other 2: _________ _________________		☐ Yes	☐ No	Other 2: _________ _______________		☐ Yes	☐ No
Results: ____				Results: ____			

Other infant examinations or abnormalities/defects

Results of infant eye exam: ☐ Normal ☐ Abnormal, describe: ____
____

Birth defect present	Full description of defect

Area to describe specific test results or defects in more detailed, if not captured above