



U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Maternal Health History Form

These data are confidential and will be stored in a secure database at the Centers for Disease Control and Prevention.

Please return completed form via SAMS or secure FTP—request access from ZIKApregnancy@cdc.gov

The form can also be sent by encrypted email to this address or by secure fax to 404-718-1013 or 404-718-2200

Maternal Health History Form		
MHH.1. State/Territory ID: _____	MHH.2. Maternal Age at Diagnosis: _____	MHH.3. State/Territory reporting: _____ MHH.4. County reporting: _____
MHH.5. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
MHH.6. Race (check all that apply): <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Unknown/Not Specified <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other, specify _____		
MHH.7. Indication for maternal Zika virus testing: <input type="checkbox"/> Exposure history only, no known fetal abnormalities <input type="checkbox"/> Exposure history and fetal abnormalities <input type="checkbox"/> No known exposure (skip to MHH.37)		
Maternal Zika Virus History		
MHH.8. Date of Zika virus symptom onset: ____/____/____ OR MHH.9. <input type="checkbox"/> Asymptomatic		
MHH.10. If symptomatic, gestational age at onset: _____(weeks, days)		
MHH.11. If gestational age or date not known, trimester of symptom onset _____ (1 st , 2 nd , 3 rd)		
MHH.12. Symptoms of mother's Zika virus disease: (check all that apply) <input type="checkbox"/> Fever (if measured) ____°F or ____°C <input type="checkbox"/> Arthralgia <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Rash <input type="checkbox"/> Other clinical presentation _____		
MHH.13. If rash, check all that apply <input type="checkbox"/> Maculopapular <input type="checkbox"/> Petechial <input type="checkbox"/> Purpuric <input type="checkbox"/> Pruritic Describe rash distribution _____		
MHH.14. Hospitalized for Zika virus disease <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
MHH.15. Maternal Death <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown MHH.16. If yes, cause of death _____		
MHH.17. If yes, date of death ____/____/____		
MHH.18. What was the suspected mode of Zika virus transmission? <input type="checkbox"/> Human-mosquito-human (vector) <input type="checkbox"/> Sexual <input type="checkbox"/> Other, please specify _____ <input type="checkbox"/> Unknown		
MHH.19. Did the woman spend time in any areas <u>outside</u> the US states or US territories where there was active Zika virus transmission during the periconceptional period or during pregnancy? (http://www.cdc.gov/zika/geo/active-countries.html) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown (If 'no' or 'unknown', skip to MHH 26)		
MHH.20. If yes, please characterize the type of travel: <input type="checkbox"/> Incoming travel (one way travel to US states <u>from</u> an area with active Zika virus transmission) <input type="checkbox"/> Incoming travel (one way travel to US territories <u>from</u> an area with active Zika virus transmission) <input type="checkbox"/> Outgoing and incoming travel (roundtrip <u>from</u> US states <u>to</u> an area with active Zika virus transmission) <input type="checkbox"/> Outgoing and incoming travel (roundtrip <u>from</u> US territories <u>to</u> an area with active Zika virus transmission)		

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If incoming or outgoing travel, please list location and dates of travel:	
MHH.21. Country of exposure (1) _____	MHH.22. Start Date ____/____/____ End Date ____/____/____ <input type="checkbox"/> Start date is same as LMP
MHH.23. Country of exposure (2) _____	MHH.24. Start Date ____/____/____ End Date ____/____/____ <input type="checkbox"/> Start date is same as LMP
MHH.25. Country of exposure (3) _____	MHH.26. Start Date ____/____/____ End Date ____/____/____ <input type="checkbox"/> Start date is same as LMP
MHH.27. Was the Zika virus exposure within the 50 states, DC, or territories? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
If yes, separately list each state or territory where Zika virus exposure occurred, and dates of possible exposure:	
MHH.28. State or territory 1 _____	MHH.29. Start Date ____/____/____ End Date ____/____/____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
MHH.30. State or territory 2 _____	MHH.31. Start Date ____/____/____ End Date ____/____/____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
MHH.32. State or territory 3 _____	MHH.33. Start Date ____/____/____ End Date ____/____/____ <input type="checkbox"/> Start date is same as LMP <input type="checkbox"/> Still at location
MHH.34. If suspected mode of transmission is sexual, was the pregnant woman's sexual partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <i>Please check all that apply</i>	
MHH.35. Did any sexual partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of <u>spending any time in an area with active Zika virus transmission</u> ? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.36. If yes, was there unprotected sexual contact while partner(s) had this illness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.37. Did partner have a test that demonstrated laboratory evidence of Zika virus infection? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Maternal Health History (<i>Underlying maternal illness</i>)	
MHH.38. Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.39. Maternal Phenylketonuria (PKU) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.40. Hypothyroidism <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.41. High Blood Pressure or Hypertension <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.42. Other underlying illness(es): <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
MHH.43. If yes, specify: _____	
Pregnancy Information	
MHH.44. Last menstrual period (LMP): ____/____/____	MHH.45. Estimated delivery date (EDD): ____/____/____
MHH.46. Estimated delivery date based on (<i>check all that apply</i>): <input type="checkbox"/> LMP <input type="checkbox"/> 1 st trimester ultrasound <input type="checkbox"/> 2 nd trimester ultrasound <input type="checkbox"/> 3 rd trimester ultrasound <input type="checkbox"/> Other, specify _____	
OB	MHH.47. # pregnancies (including current pregnancy) _____ MHH.48. # living children _____

Registry ID _____

State/Territory ID _____

Approved
OMB No. 0920-1101
Exp. 08/31/2016

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History: MHH.49. # miscarriages _____		MHH.50. # elective terminations _____
MHH.51. Prior fetus/infant with microcephaly: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
MHH.52. If yes, cause genetic?: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
MHH.53. Gestation: <input type="checkbox"/> Single <input type="checkbox"/> Twins <input type="checkbox"/> Triplets+		
Substance use during this pregnancy:	MHH.54. Alcohol use:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
	MHH.55. Cocaine use:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
	MHH.56. Smoking:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Complications during current pregnancy		
MHH.57.	Toxoplasmosis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.58.	Cytomegalovirus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.59.	Herpes Simplex infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.60.	Rubella infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.61.	Lymphocytic choriomeningitis virus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.62.	Syphilis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.63. If yes for infection testing during current pregnancy, please describe results: 		
MHH.64.	Fetal genetic abnormality:	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe _____ <input type="checkbox"/> Unknown
MHH.65.	Gestational diabetes:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.66.	Pregnancy-related hypertension:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.67.	Intrauterine death of a twin:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
MHH.68.	Other: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	MHH.67. If yes, please specify _____
MHH.69. Medications during pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
MHH.70. If yes, specify (<i>please specify type and see guide for further instructions</i>):_		
Pregnancy Losses: Please also complete pertinent sections of neonatal assessment form		
MHH.71. Did this pregnancy end in miscarriage (<20 weeks of gestation)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
		MHH.72. Date: ____/____/____ OR gestational age _____ weeks
MHH.73. Please describe any abnormalities noted _____		
MHH.74. Did this pregnancy end in stillbirth (intrauterine fetal demise) (≥20 weeks of gestation)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
		MHH.75. Date: ____/____/____ OR gestational age _____ weeks
MHH.76. Please describe any abnormalities noted _____		
MHH.77. Was this pregnancy terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
		MHH.78. Date: ____/____/____ OR gestational age _____ weeks
MHH.79. Please describe any abnormalities noted _____		
Maternal Prenatal Imaging and Diagnostics		

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MHH.80. Date(s) of ultrasound(s): ____/____/____ <input type="checkbox"/> MHH.81. Check if date approximated MHH.82. If date not known, Gestational age ----- (weeks, days)	MHH.83. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	MHH.84. <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	MHH.85. Head circumference (HC) _____cm			
	MHH.86. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (by physician report)			
	MHH.87. Biparietal diameter (BPD) _____cm			
	MHH.88. Femur length (FL) _____cm			
	MHH.89. Abdominal circumference (AC) _____cm			
	MHH.90. <input type="checkbox"/> Symmetric intrauterine growth restriction (IUGR) <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
	MHH.91. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.92. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.93. Cerebral /cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.94. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.95. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.96. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.97. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.98. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.99. Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.100. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
MHH.101. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.102. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes	
MHH.103. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.104. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes	
MHH.105. Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.106. Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
MHH.107. Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.108. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes	
MHH.109. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.110. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes	
MHH.111. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:		
MHH.112. Description of abnormal ultrasound findings:				
MHH.113. Date(s) of Ultrasound(s): ____/____/____ <input type="checkbox"/> MHH.114. check	MHH.116. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	MHH.117. <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	MHH.118. Head circumference (HC) _____cm			
	MHH.119. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (by physician report)			
	MHH.120. Biparietal diameter (BPD) _____cm			
MHH.121. Femur length (FL) _____cm				

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<i>if date approximated</i> MHH.115. <i>if date not known, gestational age ----- (weeks, days)</i>	MHH.122. Abdominal circumference (AC) _____ cm			
	MHH.123. <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
	MHH.124. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.125. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.126. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.127. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.128. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.129. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.130. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.131. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.132. Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.133. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.134. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.135. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.136. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.137. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.138. Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.139. Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.140. Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.141. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.142. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.143. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.144. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:		
MHH.145. Description of abnormal ultrasound findings:				
MHH.146. Date(s) of Ultrasound(s): ____/____/____ <input type="checkbox"/> MHH.147. <i>check if date approximated</i> MHH.148. <i>if date not known, gestational age ----- (weeks, days)</i>	MHH.149. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	MHH.150. <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	MHH.151. Head circumference (HC) _____ cm			
	MHH.152. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (<i>by physician report</i>)			
	MHH.153. Biparietal diameter (BPD) _____ cm			
	MHH.154. Femur length (FL) _____ cm			
	MHH.155. Abdominal circumference (AC) _____ cm			
	MHH.156. <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
MHH.157. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.158. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes	
MHH.159. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.160. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes	

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	MHH.161. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.162. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.163. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.164. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.165. Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.166. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.167. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.168. Anencephaly / Acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.169. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.170. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.171. Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.172. Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.173. Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.174. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.175. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.176. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.177. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:	
MHH.178. Description of abnormal ultrasound findings:				
For additional ultrasounds or MRIs, please request a supplementary imaging form				
MHH.179. Fetal MRI performed: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please answer questions below)				
MHH.180. Date(s) of MRI(s): ____/____/____ <input type="checkbox"/> MHH.181. check if date is approximated	MHH.183. Overall fetal MRI results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	MHH.184. <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> MRI report			
	MHH.185. Head circumference (HC) ____cm			
	MHH.186. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (by physician report)			
	MHH.187. Biparietal diameter (BPD) ____cm			
	MHH.188. Femur length (FL) ____cm			
MHH.189. Abdominal circumference (AC) ____cm				
MHH.190. <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)				
MHH.182. if date not known, gestational age ----- (weeks, days)	MHH.191. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.192. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.193. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.194. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.195. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.196. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.197. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.198. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.199. Moderate or severe ventriculomegaly / hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.200. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent	<input type="checkbox"/> No <input type="checkbox"/> Yes

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			occipital bone, scalp rugae)	
	MHH.201. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.202. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.203. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.204. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.205. Holoprosencephaly / arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.206. Structural eye abnormalities / dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.207. Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.208. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.209. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	MHH.210. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes
	MHH.211. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, describe:	

MHH.212. Description of abnormal MRI findings:

MHH.213. Amniocentesis performed: No Yes

If Zika virus testing performed on amniotic fluid, please enter in Laboratory Results Form.

If cytogenetic testing performed on amniotic fluid, please enter below.

Prenatal (Fetal) Cytogenetic Testing

MHH.214. Prenatal (fetal) cytogenetic testing performed: No Yes (If yes, please answer questions below)

MHH.215. Cytogenetic Tests

- Karyotype
 FISH
 CGH microarray
 Cell-free DNA
 Other, specify

MHH.216. Date of test:

____/____/____

MHH.217. Gestational Age:
(weeks, days) or

Trimester: 1st 2nd 3rd

MHH.218. Specimen type:

- Amniocentesis
 Chorionic Villus Sampling
 (CVS)
 Maternal Serum
 Other, specify

MHH.219. Test Result

- Normal
 Abnormal
 Unknown

MHH.220. Description of abnormal cytogenetic testing findings:

Prenatal (Fetal) Cytogenetic Testing

MHH.221. Prenatal (fetal) cytogenetic testing performed: No Yes (If yes, please answer questions below)

MHH.222. Cytogenetic Tests

- Karyotype
 FISH
 CGH microarray
 Cell-free DNA
 Other, specify

MHH.223. Date of test

____/____/____

MHH.224. Gestational Age:
(weeks, days) or

Trimester: 1st 2nd 3rd

MHH.225. Specimen type:

- Amniocentesis
 Chorionic Villus Sampling
 (CVS)
 Maternal Serum
 Other, specify

MHH.226. Test Result

- Normal
 Abnormal
 Unknown

Registry ID _____

State/Territory ID _____

Approved
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MHH.227. Description of abnormal cytogenetic testing findings:			
Health Department Information			
MHH.228. Name of person completing form: _____			
MHH.229. Phone: _____ MHH.230. Email: _____			
MHH.231. Date form completed ___/___/___			
Internal use only			
Date entered ___/___/___	Data Entry Notes:		
Data Entry POC Initials: _____			
<small>Public reporting burden of this collection of information is estimated to average 15 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 E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-1101).</small>			