ZIKV RNA Persistence (ZIRP): Pregnant Woman Enrollment Questionnaire

TO BE COMPLETED BY PATIENT

**Part I:Demographics**

*Thank you for agreeing to participate in this study. If you at any point have any questions about the questions in this form please ask the study staff. First, we will start by asking you some questions about yourself.*

1. What was your **pre-pregnancy** weight/height?

Weight \_\_\_\_\_\_\_\_ 🞎1 Pounds 🞎2 Kilograms 🞎77 Don’t know 🞎88 Refuse

Height \_\_\_\_\_\_\_\_ 🞎1 Inches 🞎2 Centimeters 🞎77 Don’t know 🞎88 Refuse

1. What is your birthdate? \_\_ \_\_/\_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ 🞎77 Don’t know 🞎88 Refuse

M M D D Y Y Y Y

3. What is the highest level of education that you have completed?

🞎1 Less than primary 🞎2 Primary 🞎3 Secondary 🞎4 Technical 🞎5 University or +

🞎77 Don’t know 🞎88 Refuse

4. What is your marital status?

🞎1 Single 🞎2 Married or domestic partnership 🞎3 Widowed 🞎4 Divorced 🞎5Separated 🞎6 Other 🞎77 Don’t know 🞎88 Refuse

5. What type of medical insurance do you have?

🞎1 Reforma (Medicaid) 🞎2 Private (through work, spouse or parents) 🞎3 Self-paid 🞎4 None 🞎77 Don’t know 🞎88 Refuse

6. What type of home do you live in?

🞎1 House/apartment (owned) 🞎2 House/apartment (rented) 🞎3 Public housing 🞎4 Lives with friends or relatives 🞎5 Homeless 🞎*88 Refuse*

**Part II:Medical History**

*We will now ask you questions about your past medical history.*

7. Please indicate if you have had of any of the following conditions by marking “yes” or “no”. If you mark yes in any of the conditions please fill out the third column to the right of each individual condition. If you are unsure about the diagnosis date please provide your best guess or mark “not sure”.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Don’t know | **If yes……,** |
| Asthma |  |  |  | Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Blood transfusion |  |  |  | Date of Last Transfusion:  (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Cancer |  |  |  | Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Cardiovascular (Heart) Disease |  |  |  | 🞎 Pulmonary Embolism  🞎 Rheumatic Heart Disease  🞎 Congenital Heart Disease  🞎 Peripheral Arterial Disease  🞎 Aortic Aneurysm and Dissection  🞎 Deep venous thrombosis  🞎 Pulmonary Embolism  🞎 Stroke  🞎Other  🞎 Don’t Know  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Diabetes |  |  |  | Type:  🞎 Type I  🞎 Type II  🞎 Gestational diabetes  🞎 Not Sure  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Hepatitis |  |  |  | Type:  🞎 A  🞎 B  🞎 C  🞎 D  🞎 E  🞎 Don’t Know  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| High Blood Pressure |  |  |  | Diagnosis Date(mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| HIV |  |  |  | Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Kidney Disease |  |  |  | Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Liver Disease |  |  |  | Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Mosquito-borne illnesses |  |  |  | 🞎2 Dengue  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure    🞎3 Chikungunya  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |
| Sexually Transmitted Disease |  |  |  | Type:  🞎 Chlamydia  🞎 Gonorrhea  🞎 Genital Herpes  🞎 Genital Warts  🞎 Syphillis  🞎 Crabs  🞎 Trichomoniasis  🞎Other  🞎 Don’t Know  Diagnosis Date (mm/dd/yyyy): \_\_\_\_\_\_\_ 🞎 Not Sure |

**Part III: Pregnancy**

*We will now ask you questions about your pregnancy history.*

8. Do you know the first day of your last menstrual cycle? 🞎1 Yes 🞎0 No

8.1 If Yes, what was the date?, \_\_ \_\_/\_\_ \_\_ /\_\_ \_\_ \_\_ \_\_

M M D D Y Y Y Y

9. Do you know your due date? 🞎1 Yes 🞎0 No

9.1 If Yes, what is your due date?, \_\_ \_\_/\_\_ \_\_ /\_\_ \_\_ \_\_ \_\_

M M D D Y Y Y Y

10. How many babies are you expecting?: 🞎1 Single 🞎2 Twins 🞎3 Triplets 🞎4 Other

11. How many times were you pregnant before this pregnancy?

\_\_\_\_\_\_\_\_\_ times 🞎1 This is my first pregnancy 🞎77 Don’t know 🞎88 Refuse

12. **During this pregnancy,** have you been told you have gestational diabetes?

🞎1 Yes 🞎0 No 🞎77 Don’t know 🞎88 Refuse

**Part IV: Sexual History**

*We will now ask you questions about your sexual history.*

13. How many men have you had unprotected sex with during your pregnancy?

🞎1 1 🞎2 2 🞎3 3 or more 🞎4 None 🞎77 Don’t know 🞎88 Refuse

14. Since the start of your pregnancy, how often have you had vaginal sex with a man? Choose the best answer.

🞎1 Once a day or more

🞎2 Two or more times a week

🞎3 Once a month

🞎4 Less than once a month

🞎5 Never

🞎77 Don’t know

🞎88 Refuse

15. Since the start of your pregnancy, when you had sex, how often has your partner used a condom?

🞎1 Always 🞎2 Very often 🞎3 Sometimes 🞎4 Rarely 🞎5 Never 🞎6 Not applicable 🞎77 Don’t know 🞎88 Refuse

**Part V: Medications**

*We will now ask you questions about any prescription medications, over the counter medications, and supplements you are currently taking*

16. Are you taking any prescription medications? 🞎1 Yes 🞎0 No 🞎77 Don’t know 🞎88 Refuse

16.1 If Yes, Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Are you taking any over the counter medications? 🞎1 Yes 🞎0 No 🞎77 Don’t know 🞎88 Refuse

17.1 If Yes, Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Are you taking any vitamins/minerals/supplements? 🞎1 Yes 🞎0 No 🞎77 Don’t know 🞎88 Refuse

18.1 If Yes, Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO BE COMPLETED THROUGH MEDICAL RECORD ABSTRACTION

**Part I: Demographics**

1. What is the patient’s current weight/height?

Weight \_\_\_\_\_\_\_\_ 🞎1 *Pounds* 🞎2 *Kilograms* 🞎77 *Don’t know* 🞎88 *Refused*

Height \_\_\_\_\_\_\_\_ 🞎1 *Inches* 🞎2 *Centimeters* 🞎77 *Don’t know* 🞎88 *Refused*

1. Has the patient been vaccinated for…?

|  |  |
| --- | --- |
| Yellow fever | 🞎1 Yes 🞎0 No 🞎77 Don’t know |
|  | If yes, Date of most recent vaccination (mm/dd/yyyy): \_\_\_\_\_\_\_ |
| Dengue | 🞎1 Yes 🞎0 No 🞎77 Don’t know |
|  | If yes, Date of most recent vaccination (mm/dd/yyyy): \_\_\_\_\_\_\_ |
| Influenza | 🞎1 Yes 🞎0 No 🞎77 Don’t know |
|  | If yes, Date of most recent vaccination (mm/dd/yyyy): \_\_\_\_\_\_\_ |

**Part II: Obstetric History**

*Complete if patient reported having previous pregnacies.*

3. Did the patient have any of the following in their previous pregnancies…

|  |  |
| --- | --- |
| Live Birth | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
|  | If yes, # of pregnancies: \_\_\_\_\_\_\_\_\_\_, year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_ |
| Miscarriage (loss before 20th week) | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
|  | If yes, # of pregnancies: \_\_\_\_\_\_\_\_\_\_, year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_ |
| Stillbirth (loss at or after the 20th week) | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
|  | If yes, # of pregnancies: \_\_\_\_\_\_\_\_\_\_, year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_ |
| Abortion | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
|  | If yes, # of pregnancies: \_\_\_\_\_\_\_\_\_\_, year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_ |
| Ectopic or molar pregnancy | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
|  | If yes, # of pregnancies: \_\_\_\_\_\_\_\_\_\_, year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_  year \_\_\_\_\_\_\_\_\_\_ |

4. During any of the patient's previous pregnancies, did they …?

|  |  |
| --- | --- |
| Have gestational diabetes (diabetes diagnosed in pregnancy) | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
| Have a premature birth (delivery before 37 weeks) | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
| Have a Cesarean section | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |
| Have a baby with a major birth defect | 🞎1 Yes 🞎0 No 🞎77 *Don’t know* |