Form Approved
OMB Control No.: 0920-XXXX
Expiration date: XX/XX/XXXX

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

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

2. 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
   ☐$_5$Separated ☐$_6$ 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?

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

☐$_1$ 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

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

				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

Form Approved
OMB Control No.: 0920-XXXX
Expiration date: XX/XX/XXXX

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

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

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

☐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 _____

Form Approved
OMB Control No.: 0920-XXXX
Expiration date: XX/XX/XXXX

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

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 _____

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

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*

2. 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 _____

Site code	Participant code	Pregnant Woman
I___I	I___I___I___I	I_**0**_I

Today's date: _____/_____/_____
MM DD YYYY

	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*

Study code	Site code	Participant code	Participant initials (first /last name)
I_Z_I	I___I	I___I___I___I	I___I___I