

Site code Participant code Pregnant Woman



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Today's date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

## ZIKV RNA Persistence (ZIRP): Pregnant Woman Enrollment Questionnaire

TO BE COMPLETED BY PATIENT

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### **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 \_\_\_\_\_ <sub>1</sub> Pounds   <sub>2</sub> Kilograms   <sub>77</sub> Don't know   <sub>88</sub> Refuse  
Height \_\_\_\_\_ <sub>1</sub> Inches   <sub>2</sub> Centimeters   <sub>77</sub> Don't know   <sub>88</sub> Refuse

2. What is your birthdate?      \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
  M M D D   Y Y Y Y              <sub>77</sub> Don't know   <sub>88</sub> Refuse

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

<sub>1</sub> Less than primary   <sub>2</sub> Primary   <sub>3</sub> Secondary   <sub>4</sub> Technical   <sub>5</sub> University or +  
<sub>77</sub> Don't know   <sub>88</sub> Refuse

4. What is your marital status?

<sub>1</sub> Single   <sub>2</sub> Married or domestic partnership   <sub>3</sub> Widowed   <sub>4</sub> Divorced  
<sub>5</sub> Separated   <sub>6</sub> Other   <sub>77</sub> Don't know   <sub>88</sub> Refuse

5. What type of medical insurance do you have?

<sub>1</sub> Reforma (Medicaid)   <sub>2</sub> Private (through work, spouse or parents)   <sub>3</sub> Self-paid  
<sub>4</sub> None   <sub>77</sub> Don't know   <sub>88</sub> Refuse

6. What type of home do you live in?

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



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**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): _____ <input type="checkbox"/> Not Sure
Blood transfusion				Date of Last Transfusion: (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Cancer				Type: _____ Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Cardiovascular (Heart) Disease				<input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Peripheral Arterial Disease <input type="checkbox"/> Aortic Aneurysm and Dissection <input type="checkbox"/> Deep venous thrombosis <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Stroke <input type="checkbox"/> Other <input type="checkbox"/> Don't Know  Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Diabetes				Type: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Not Sure  Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure

Public reporting burden of this collection of information is estimated to average 8 minutes, 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 (0920-1189).



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Hepatitis				Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> Don't Know Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
High Blood Pressure				Diagnosis Date(mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
HIV				Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Kidney Disease				Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Liver Disease				Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Mosquito-borne illnesses				<input type="checkbox"/> <sub>2</sub> Dengue Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure  <input type="checkbox"/> <sub>3</sub> Chikungunya Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure
Sexually Transmitted Disease				Type: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Genital Warts <input type="checkbox"/> Syphilis <input type="checkbox"/> Crabs <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Other <input type="checkbox"/> Don't Know  Diagnosis Date (mm/dd/yyyy): _____ <input type="checkbox"/> Not Sure

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**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? <sub>1</sub> Yes <sub>0</sub> No

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

9. Do you know your due date? <sub>1</sub> Yes <sub>0</sub> 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?: <sub>1</sub> Single <sub>2</sub> Twins <sub>3</sub> Triplets <sub>4</sub> Other

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

\_\_\_\_\_ times <sub>1</sub> This is my first pregnancy <sub>77</sub> Don't know <sub>88</sub> Refuse

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

<sub>1</sub> Yes <sub>0</sub> No <sub>77</sub> Don't know <sub>88</sub> 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?

<sub>1</sub> 1 <sub>2</sub> 2 <sub>3</sub> 3 or more <sub>4</sub> None <sub>77</sub> Don't know <sub>88</sub> Refuse



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

- <sub>1</sub> Once a day or more
- <sub>2</sub> Two or more times a week
- <sub>3</sub> Once a month
- <sub>4</sub> Less than once a month
- <sub>5</sub> Never
- <sub>77</sub> Don't know
- <sub>88</sub> Refuse

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

- <sub>1</sub> Always
- <sub>2</sub> Very often
- <sub>3</sub> Sometimes
- <sub>4</sub> Rarely
- <sub>5</sub> Never
- <sub>6</sub> Not applicable
- <sub>77</sub> Don't know
- <sub>88</sub> 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? <sub>1</sub> Yes <sub>0</sub> No <sub>77</sub> Don't know <sub>88</sub> Refuse

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

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

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

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

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

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17. Are you taking any over the counter medications? <sub>1</sub> Yes <sub>0</sub> No <sub>77</sub> Don't know <sub>88</sub> Refuse

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

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

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

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

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

18. Are you taking any vitamins/minerals/supplements? <sub>1</sub> Yes <sub>0</sub> No <sub>77</sub> Don't know <sub>88</sub> Refuse

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

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

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

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

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

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TO BE COMPLETED THROUGH MEDICAL RECORD ABSTRACTION

**Part I: Demographics**

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

Weight \_\_\_\_\_ <sub>1</sub> Pounds <sub>2</sub> Kilograms <sub>77</sub> Don't know <sub>88</sub> Refused  
 Height \_\_\_\_\_ <sub>1</sub> Inches <sub>2</sub> Centimeters <sub>77</sub> Don't know <sub>88</sub> Refused

2. Has the patient been vaccinated for...?

Yellow fever	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, Date of most recent vaccination (mm/dd/yyyy): _____
Dengue	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, Date of most recent vaccination (mm/dd/yyyy): _____
Influenza	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, Date of most recent vaccination (mm/dd/yyyy): _____

**Part II: Obstetric History**

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Complete if patient reported having previous pregnancies.

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

Live Birth	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, # of pregnancies: _____, year _____ year _____ year _____ year _____
Miscarriage (loss before 20 <sup>th</sup> week)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, # of pregnancies: _____, year _____ year _____ year _____ year _____
Stillbirth (loss at or after the 20 <sup>th</sup> week)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, # of pregnancies: _____, year _____ year _____ year _____ year _____
Abortion	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, # of pregnancies: _____, year _____ year _____ year _____ year _____
Ectopic or molar pregnancy	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>77</sub> Don't know
	If yes, # of pregnancies: _____, year _____

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

Have gestational diabetes (diabetes diagnosed in pregnancy)	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>
Have a premature birth (delivery before 37 weeks)	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>
Have a Cesarean section	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>
Have a baby with a major birth defect	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	<input type="checkbox"/> <sub>77</sub> <i>Don't know</i>

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Study code

Site code

Participant code

Participant initials (first /last name)

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