Registry ID ______________ State/Territory ID _____________________________

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

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

These data are c 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

MHH.1. State/Territory ID: ______________________________

MHH.2. Maternal Age at Diagnosis: _____

MHH.3. State/Territory reporting: _________________

MHH.4. County reporting: _________________________

MHH.5. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

MHH.6. Race *(check all that apply)*:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Unknown/Not Specified
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other, specify_______________________

MHH.7. Indication for maternal Zika virus testing:
☐ Exposure history only, no known fetal abnormalities
☐ Exposure history and fetal abnormalities
☐ No known exposure (*skip to MHH.37*)

Maternal Zika Virus History

MHH.8. Date of Zika virus symptom onset: _____/_____/_____ **OR** **MHH.9.** ☐ Asymptomatic

MHH.10. If symptomatic, gestational age at onset: ____________________(weeks, days)

MHH.11. If gestational age or date not known, trimester of symptom onset __________________ (1st, 2nd, 3rd)

MHH.12. Symptoms of mother's Zika virus disease: *(check all that apply)*

☐ Fever *(if measured)* _____°F or _____°C ☐ Arthralgia ☐ Conjunctivitis ☐ Rash

☐ Other clinical presentation____

MHH.13. If rash, check all that apply ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Pruritic

Describe rash distribution____

MHH.14. Hospitalized for Zika virus disease ☐ No ☐ Yes ☐ Unknown

MHH.15. Maternal Death ☐ No ☐ Yes ☐ 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?
☐ Human-mosquito-human (vector) ☐ Sexual ☐ Other, please specify_______________________ ☐ Unknown

MHH.19. Did the woman spend time in any areas outside 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)

☐ No ☐ Yes ☐ Unknown (*If 'no' or 'unknown', skip to MHH 26*)

MHH.20. ***If yes*, please characterize the type of travel:**
☐ Incoming travel (one way travel to US states from an area with active Zika virus transmission)
☐ Incoming travel (one way travel to US territories from an area with active Zika virus transmission)
☐ Outgoing and incoming travel (roundtrip from US states to an area with active Zika virus transmission)
☐ Outgoing and incoming travel (roundtrip from US territories to 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 ____/_____/_____ ☐ Start date is same as LMP
MHH.23. Country of exposure (2) ________________________________	**MHH.24.** Start Date ____/_____/_____ End Date ____/_____/_____ ☐ Start date is same as LMP
MHH.25. Country of exposure (3) ________________________________	**MHH.26.** Start Date ____/_____/_____ End Date ____/_____/_____ ☐ Start date is same as LMP

MHH.27. Was the Zika virus exposure within the 50 states, DC, or territories? ☐ No ☐ Yes ☐ 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 _____/_____/_____ ☐ Start date is same as LMP ☐ Still at location
MHH.30. State or territory 2 ________________________________	**MHH.31.** Start Date _____/_____/_____ End Date _____/_____/_____ ☐ Start date is same as LMP ☐ Still at location
MHH.32. State or territory 3 ________________________________	**MHH.33.** Start Date _____/_____/_____ End Date _____/_____/_____ ☐ Start date is same as LMP ☐ Still at location

MHH.34. If suspected mode of transmission is sexual, was the pregnant woman's sexual partner(s):
☐ Male ☐ Female *Please check all that apply*

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</u> an area with active Zika virus transmission?
☐ No ☐ Yes ☐ Unknown

MHH.36. If yes, was there unprotected sexual contact while partner(s) had this illness?
☐ No ☐ Yes ☐ Unknown

MHH.37. Did partner have a test that demonstrated laboratory evidence of Zika virus infection? ☐ No ☐ Yes ☐ Unknown

Maternal Health History *(Underlying maternal illness)*

MHH.38. Diabetes ☐ No ☐ Yes ☐ Unknown
MHH.39. Maternal Phenylketonuria (PKU) ☐ No ☐ Yes ☐ Unknown
MHH.40. Hypothyroidism ☐ No ☐ Yes ☐ Unknown
MHH.41. High Blood Pressure or Hypertension ☐ No ☐ Yes ☐ Unknown
MHH.42. Other underlying illness(es): ☐ No ☐ Yes ☐ 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 (*check all that apply*):
☐ LMP ☐ 1st trimester ultrasound ☐ 2nd trimester ultrasound ☐ 3rd trimester ultrasound
☐ Other, specify ____

OB **MHH.47. # pregnancies (including current pregnancy)** _____ **MHH.48. # living children** _____

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History: **MHH.49. # miscarriages** _____ **MHH.50. # elective terminations** _____

MHH.51. Prior fetus/infant with microcephaly: ☐ No ☐ Yes ☐ Unknown
MHH.52. If yes, cause genetic?: ☐ No ☐ Yes ☐ Unknown

MHH.53. Gestation: ☐ Single ☐ Twins ☐ Triplets+

Substance use during this pregnancy:
MHH.54. Alcohol use: ☐ No ☐ Yes ☐ Unknown
MHH.55. Cocaine use: ☐ No ☐ Yes ☐ Unknown
MHH.56. Smoking: ☐ No ☐ Yes ☐ Unknown

Complications during current pregnancy

MHH.57.	Toxoplasmosis infection:	☐ No ☐ Yes ☐ Unknown
MHH.58.	Cytomegalovirus infection:	☐ No ☐ Yes ☐ Unknown
MHH.59.	Herpes Simplex infection:	☐ No ☐ Yes ☐ Unknown
MHH.60.	Rubella infection:	☐ No ☐ Yes ☐ Unknown
MHH.61.	Lymphocytic choriomeningitis virus infection:	☐ No ☐ Yes ☐ Unknown
MHH.62.	Syphilis infection:	☐ No ☐ Yes ☐ Unknown

MHH.63. If yes for infection testing during current pregnancy, please describe results:

MHH.64.	Fetal genetic abnormality:	☐ No ☐ Yes, describe __________ ☐ Unknown
MHH.65.	Gestational diabetes:	☐ No ☐ Yes ☐ Unknown
MHH.66.	Pregnancy-related hypertension:	☐ No ☐ Yes ☐ Unknown
MHH.67.	Intrauterine death of a twin:	☐ No ☐ Yes ☐ Unknown
MHH.68.	Other: ☐ No ☐ Yes ☐ Unknown **MHH.67.** If yes, please specify ______________________________	

MHH.69. Medications during pregnancy: ☐ No ☐ Yes ☐ Unknown
MHH.70. If yes, specify (*please specify type and see guide for further instructions*):_

Pregnancy Losses: *Please also complete pertinent sections of neonatal assessment form*

MHH.71. Did this pregnancy end in miscarriage (<20 weeks of gestation)?
☐ No ☐ Yes ☐ 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)?
☐ No ☐ Yes ☐ Unknown **MHH.75.** Date: _____/_____/_____ OR gestational age______ weeks
MHH.76. Please describe any abnormalities noted______________________________

MHH.77. Was this pregnancy terminated?
☐ No ☐ Yes ☐ Unknown **MHH.78.** Date: _____/_____/_____ OR gestational age ______ weeks
MHH.79. Please describe any abnormalities noted______________________________

Maternal Prenatal Imaging and Diagnostics

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<table>
<tr><td rowspan="16">MHH.80. Date(s) of ultrasound(s):
___/___/___
☐ MHH.81. Check if date approximated

MHH.82. If date not known, Gestational age
____
(weeks, days)</td><td colspan="4">MHH.83. Overall fetal ultrasound results: ☐ Normal ☐ Abnormal</td></tr>
<tr><td colspan="4">MHH.84. ☐ Reported by patient/healthcare provider ☐ Ultrasound report</td></tr>
<tr><td colspan="4">MHH.85. Head circumference (HC) ________cm
MHH.86. ☐ Normal ☐ Abnormal (by physician report)</td></tr>
<tr><td colspan="4">MHH.87. Biparietal diameter (BPD) _______cm
MHH.88. Femur length (FL) ______cm
MHH.89. Abdominal circumference (AC) ______cm</td></tr>
<tr><td colspan="4">MHH.90. ☐ Symmetric intrauterine growth restriction (IUGR)
☐ Asymmetric IUGR (HC>AC or HC>FL)</td></tr>
<tr><td>MHH.91. Microcephaly</td><td>☐ No ☐ Yes</td><td>MHH.92. Intracranial calcifications</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.93. Cerebral /cortical atrophy</td><td>☐ No ☐ Yes</td><td>MHH.94. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.95. Corpus callosum abnormalities</td><td>☐ No ☐ Yes</td><td>MHH.96. Cerebellar abnormalities</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.97. Porencephaly</td><td>☐ No ☐ Yes</td><td>MHH.98. Hydranencephaly</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.99. Moderate or severe ventriculomegaly / hydrocephaly</td><td>☐ No ☐ Yes</td><td>MHH.100. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.101. Other major brain abnormalities</td><td>☐ No ☐ Yes</td><td>MHH.102. Anencephaly / acrania</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.103. Encephalocele</td><td>☐ No ☐ Yes</td><td>MHH.104. Spina bifida</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.105. Holoprosencephaly / arhinencephaly</td><td>☐ No ☐ Yes</td><td>MHH.106. Structural eye abnormalities / dysplasia</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.107. Arthrogryposis</td><td>☐ No ☐ Yes</td><td>MHH.108. Clubfoot</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.109. Hydrops</td><td>☐ No ☐ Yes</td><td>MHH.110. Ascites</td><td>☐ No ☐ Yes</td></tr>
<tr><td>MHH.111. Other</td><td colspan="3">☐ No ☐ Yes If yes, describe:</td></tr>
<tr><td colspan="5">MHH.112. Description of abnormal ultrasound findings:</td></tr>
<tr><td rowspan="4">MHH.113. Date(s) of Ultrasound(s):
____/____/____
☐ MHH.114.
check</td><td colspan="4">MHH.116. Overall fetal ultrasound results: ☐ Normal ☐ Abnormal</td></tr>
<tr><td colspan="4">MHH.117. ☐ Reported by patient/healthcare provider ☐ Ultrasound report</td></tr>
<tr><td colspan="4">MHH.118. Head circumference (HC) ________cm
MHH.119. ☐ Normal ☐ Abnormal (by physician report)</td></tr>
<tr><td colspan="4">MHH.120. Biparietal diameter (BPD) _______cm
MHH.121. Femur length (FL) ______cm</td></tr>
</table>

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

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

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			occipital bone, scalp rugae)	
	MHH.201. Other major brain abnormalities	☐ No ☐ Yes	**MHH.202.** Anencephaly / acrania	☐ No ☐ Yes
	MHH.203. Encephalocele	☐ No ☐ Yes	**MHH.204.** Spina bifida	☐ No ☐ Yes
	MHH.205. Holoprosencephaly / arhinencephaly	☐ No ☐ Yes	**MHH.206.** Structural eye abnormalities / dysplasia	☐ No ☐ Yes
	MHH.207. Arthrogryposis	☐ No ☐ Yes	**MHH.208.** Clubfoot	☐ No ☐ Yes
	MHH.209. Hydrops	☐ No ☐ Yes	**MHH.210.** Ascites	☐ No ☐ Yes
	MHH.211. Other	☐ No ☐ 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	**MHH.216. Date of test:**	**MHH.218. Specimen type:**	**MHH.219. Test Result**
☐ Karyotype ☐ FISH ☐ CGH microarray ☐ Cell-free DNA ☐ Other, specify ____________________	_____/_____/______ **MHH.217. Gestational Age:** __________ **(weeks, days) or** **Trimester:** ☐1st ☐2nd ☐3rd	☐ Amniocentesis ☐ Chorionic Villus Sampling (CVS) ☐ Maternal Serum ☐ Other, specify ____________________	☐ 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	**MHH.223. Date of test**	**MHH.225. Specimen type:**	**MHH.226. Test Result**
☐ Karyotype ☐ FISH ☐ CGH microarray ☐ Cell-free DNA ☐ Other, specify ____________________	_____/_____/______ **MHH.224. Gestational Age:** __________ **(weeks, days) or** **Trimester:** ☐1st ☐2nd ☐3rd	☐ Amniocentesis ☐ Chorionic Villus Sampling (CVS) ☐ Maternal Serum ☐ Other, specify ____________________	☐ Normal ☐ Abnormal ☐ Unknown

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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 POC Initials:*** *_______*	***Data Entry Notes:***

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).