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Centers for Birth Defects Research and Prevention
Supplemental Stillbirth
Computer-Assisted Telephone Interview

Questionnaire Version 1.1

CATI Version 7.2.4

December 1, 2017

Contents

A98. JUST CLICK NEXT – THIS IS TO ESTABLISH DOB FROM CORE CATI.

A99. JUST CLICK NEXT – THIS IS TO ESTABLISH EDD FROM CORE CATI.

OPENING STATEMENT

A0. In this interview we will ask you questions mainly about your pregnancy with {name of infant}, who was born on {infant's birth date} (**for liveborns**)/ that ended on {pregnancy end date} (**for stillbirths**).

Section A: PREVIOUS PREGNANCY HISTORY

I am going to start by asking you about your **previous pregnancy** experiences.

A1. Has a prior pregnancy ended in a stillbirth?

a. Yes → CONTINUE TO A2
b. No→ SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF→ SKIP TO NEXT SECTION

A2. Was an autopsy or other type of exam done for the baby who died?

a. Yes → CONTINUE TO A3
b. No→ SKIP TO NEXT SECTION
c. DK→ SKIP TO NEXT SECTION
d. RF→ SKIP TO NEXT SECTION

A3. Did a healthcare provider tell you about the autopsy results or why he/she thought the baby died?

a. Yes→ CONTINUE TO A4
b. No→ SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF→ SKIP TO NEXT SECTION

A4. What was the reason? _____

INDEX PREGNANCY: PREGNANCY-SPECIFIC CONDITIONS

Now, I'm going to ask you about **your pregnancy** experiences for your pregnancy with {name of infant}, who was born on {infant's birth date} (**for liveborns**)/ that ended on {pregnancy end date} (**for stillbirths**).

Section B. MATERNAL PERCEPTION OF FETAL MOVEMENTS

B1. Do you remember the month when the baby first started moving?

a. Yes→ CONTINUE TO B2
b. No→ SKIP TO B3
c. DK→ SKIP TO B3
d. RF→ SKIP TO B3

B2. In what month did the movements start? [RECORD ONE]

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
c. DK
d. RF

B3. During the last three months you were pregnant, did you notice any **change** in the frequency of fetal movements?

a. Yes→ CONTINUE TO B4
b. No→ SKIP TO B7
c. DK →SKIP TO B7
d. RF→SKIP TO B7

B4. Did the frequency of movements [READ ALL]…

a. Increase? →SKIP TO B7
b. Stay the same? →SKIP TO B7
c. Decrease? →CONTINUE TO B5
d. DK →SKIP TO B7
e. RF →SKIP TO B7

B5. When was the **first time** you experienced reduced fetal movement in your pregnancy? [RECORD ONE]

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
c. DK
d. RF

B6. Was the reduced fetal movement severe enough for you to call, to mention to, or notify your healthcare provider?

a. Yes
b. No
c. DK
d. RF

B7. During the last three months you were pregnant, did you notice any change in the **strength** of fetal movement?

a. Yes →CONTINUE TO B8
b. No →SKIP TO B11
c. DK → SKIP TO B11
d. RF →SKIP TO B11

B8. Did the strength of the movements…[READ OPTIONS]

a. Increase? →SKIP TO B11
b. Stay the same? →SKIP TO B11
c. Decrease? →CONTINUE TO B9
d. DK →SKIP TO B11
e. RF →SKIP TO B11

B9. When was the **first time** you noticed a decrease in the strength of the fetal movements?

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
c. DK
d. RF

B10. Was the decrease in the strength of fetal movement severe enough for you to call, to mention, or notify your healthcare provider?

a. Yes
b. No
c. DK
d. RF

B11. Did you ever notice that the fetal movements had completely stopped?

a. Yes → GO TO B12
b. No → SKIP TO B13
c. DK → SKIP TO B13
d. RF → SKIP TO B13

B12. When was the first time you noticed that the fetal movements had completely stopped?

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
c. DK
d. RF

B13. During the last three months of your pregnancy, did you feel rhythmic movements or your baby having hiccups (short jerking movements occurring at regular intervals, for a period of time)?

a. Yes
b. No
c. DK
d. RF

Section C. MATERNAL SLEEPING POSITION

C1. What is your usual sleep position when you are **not** pregnant? PROBE: [READ OPTIONS]

a. On back
b. On stomach, with your head turned to the left or right
c. Left
d. Right
e. Combination of positions
f. DK

g. RF

C2. What was your usual sleep position during the **last month** of your pregnancy? PROBE: [READ OPTIONS]

a. On back
b. On stomach, with your head turned to the left or right
c. Left
d. Right
e. Combination of positions
f. DK
g. RF

Section D. FETAL GROWTH

D1. Did a healthcare provider tell you that the baby was not growing normally during pregnancy?

a. Yes →CONTINUE TO D2
b. NO→SKIP TO D3
c. DK→SKIP TO D3
d. RF→SKIP TO D3

D2. What did the healthcare provider tell you? _____

D3. Did you have an ultrasound during your pregnancy that showed that your baby's growth was restricted?

a. Yes → D3a
b. No→SKIP TO D4
c. DK→SKIP TO D4
d. RF→SKIP TO D4

D3a. When was it done?
a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
c. DK
d. RF

D4. Did you have any tests during your pregnancy that showed any problems involving the placenta or umbilical cord, such as placenta previa or cord knots?

a. **Yes CONTINUE TO D4a**
b. No →SKIP TO D5
c. DK →SKIP TO D5
d. RF →SKIP TO D5

D4a. What problem was found? _____

Anything else? _____

IF OUTCOME OF THE PARTICIPANT'S PREGNANCY WAS LIVEBORN, SKIP TO SECTION E (VAGINAL BLEEDING)
IF OUTCOME OF THE PARTICIPANT'S PREGNANCY WAS STILLBIRTH, CONTINUE WITH D5

D5. Was an autopsy or other type of exam done for the baby who died?

a. Yes → CONTINUE TO D6
b. No → SKIP TO D8
c. Not sure → SKIP TO D8
D. RF → SKIP TO D8

D6. Did a healthcare provider tell you about the autopsy results or why he/she thought the baby died?

a. Yes → CONTINUE TO D7
b. No → SKIP TO D8
c. Not sure → SKIP TO D8
D. RF → SKIP TO D8

D7. What was the reason? _____

D8. Did a healthcare provider do any genetic tests because the baby died?

a. Yes →CONTINUE TO D10
b. No →SKIP TO NEXT SECTION
c. DK →SKIP TO NEXT SECTION
D. RF →SKIP TO NEXT SECTION

(There is no D9)

D10. What were the results? _____

a. DK
b. RF

Section E. VAGINAL BLEEDING

E1. At any time during your pregnancy, did you experience more than one pad's worth of bleeding during a one-day period?

a. Yes →CONTINUE TO E2
b. No →SKIP TO NEXT SECTION
c. DK →SKIP TO NEXT SECTION
d. RF →SKIP TO NEXT SECTION

E2. When was the first time you experienced this amount of bleeding in your pregnancy? [RECORD ONE]

a. _____# Weeks/Months/Trimesters OR

b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
c. DK
d. RF

E3. Before delivery, when was the **last time** you experienced this amount of bleeding? [RECORD ONE]

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] OR
c. DK
d. RF

E4. Was the bleeding severe enough for you to call, to mention to, or to notify your healthcare provider?

a. Yes
b. No
c. DK
d. RF

Section F. LOSS OF AMNIOTIC FLUID

F1. At any time during your pregnancy, did you experience enough leaking fluid to wear a pad?

a. Yes → CONTINUE TO F2
b. No → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

F2. When was the **first time** you experienced leaking fluid in your pregnancy? [RECORD ONE]

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] OR
c. DK
d. RF

F3. Was the leaking fluid severe enough for you to call, to mention to, or to notify your healthcare provider?

a. Yes
b. No
c. DK
d. RF

Section G. ABDOMINAL PAIN

G1. During this pregnancy, did you experience severe abdominal pain? [IF MOM ASKS WHAT WE MEAN BY "SEVERE", TELL HER WHATEVER SHE CONSIDERS SEVERE.]

a. Yes →CONTINUE TO G2
b. No →SKIP TO NEXT SECTION
c. DK →SKIP TO NEXT SECTION
d. RF →SKIP TO NEXT SECTION

G2. When was the first time you experienced severe abdominal pain in your pregnancy? [RECORD ONE]

a. _____# Weeks/Months/Trimesters OR
b. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] OR
c. DK
d. RF

G3. Was this abdominal pain severe enough for you to call, to mention to, or to notify your healthcare provider?

a. Yes
b. No
c. DK
d. RF

INDEX PREGNACY: SPECIFIC EXPOSURES

Section H. SPECIFIC EXPOSURES

H1. Did you take any medications to maintain your pregnancy or to prevent premature delivery; examples of such medications: 17-hydroxyprogesterone, aspirin, magnesium sulfate?

a. Yes → CONTINUE TO H1a
b. No →SKIP TO H2
c. DK →SKIP TO H2
d. RF →SKIP TO H2

H1a. What did you take? _____ Anything else?

H1b. When did you start using {medication}?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] OR
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

When did you stop using {medication}?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] OR
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

OR, How long did you take {medication}?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

H2. At any time from {second trimester start date} until the end of your pregnancy, did you smoke cigarettes?

a. YES → GO TO H2a
b. NO → SKIP TO H3
c. DK → SKIP TO H3
d. RF → SKIP TO H3

H2a. During which months did you smoke? [SELECT ALL THAT APPLY]

a. MONTH OF PREGNANCY (B3-T3)
b. DK
c. RF

H2b. How many cigarettes did you smoke per day?

a. NUMBER _____
b. DK
c. RF

H3. At any time from {second trimester start date} until the end of your pregnancy, did you use electronic cigarettes, also known as e-cigarettes?

a. Yes → IF YES, GO TO H3a
b. No → SKIP TO H4
c. DK → SKIP TO H4
d. RF → SKIP TO H4

H3a. How often did you use e-cigarettes?

a. EVERYDAY
b. SOMEDAYS
c. RARELY
d. DK
e. RF

H4. From {second trimester start date} until the end of your pregnancy, did you drink any wine, beer, mixed drinks or shots of liquor?

a. YES → GO TO H4a
b. NO → SKIP TO H5
c. DK → SKIP TO H5
d. RF → SKIP TO H5

H4a. During which months did you drink any alcoholic beverages? [SELECT ALL THAT APPLY]

a. _____ (P4, P5, P6, P7, P8, P9)
b. DK
c. RF

H4b. What was the greatest number of drinks you had on one occasion during this time period? We define one drink as one beer, one glass of wine, one mixed drink, or one shot of liquor.

a. NUMBER _____
b. DK
c. RF

H5. During your pregnancy, did any healthcare worker ever suspect you had exposure to carbon monoxide (from causes such as smoke from a fire, using faulty water heaters, using gas powered tools, vehicles, or poorly ventilated areas, car exhaust.)

a. Yes
b. No
c. DK
d. RF

ILLNESSES AND THEIR TREATMENT

I0. Introduction: During your previous telephone interview, we focused on the first trimester of your pregnancy. In this part of the interview, we will ask about some of the previously-covered topics, but this time our interest is mostly in the later period of your pregnancy, from the beginning of your second trimester until the end of your pregnancy. We will also cover some new topics. If you filled out the medication worksheet that we sent you earlier, it will be helpful if you have it in front of you when answering these questions.

Note: A MEDICATION WORKSHEET COVERING THE SECOND AND THIRD TRIMESTERS WAS SENT WITH THE INTRODUCTORY MATERIALS.

THESE QUESTIONS WILL REQUIRE THE INTERVIEWER TO HAVE ACCESS TO THE PARTICIPANT'S RESPONSES IN THE CORE CATI.

Section I. DIABETES

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF DIABETES [CORE CATI F1 = NO, DK, RF] → SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF DIABETES [CORE CATI F1 = YES] → READ:

> You previously told us that you had diabetes. Now I would like to ask some additional questions about your diabetes and any medications you may have taken to treat your diabetes from the beginning of your second trimester, that is from {second trimester start date}, until the end of your pregnancy.

I1. What type of diabetes did you or do you currently have? Was it [READ LIST]

a. Gestational, that is, during pregnancy only → CONTINUE TO I2
b. Insulin-dependent diabetes, also called Type 1, or Juvenile → SKIP TO I4
c. Non-insulin-dependent diabetes, also called Type 2, or Adult onset → SKIP TO I4
d. DK → SKIP TO I4
e. RF → SKIP TO I4

I2. When were you first diagnosed with gestational diabetes? [READ LIST, a-c]

a. During a previous pregnancy only → SKIP TO NEXT SECTION
b. During this [index] pregnancy only → CONTINUE TO I3
c. During this [index] pregnancy and a previous pregnancy → CONTINUE TO I3
d. DK → SKIP TO I4
e. RF → SKIP TO I4

I3. When was gestational diabetes diagnosed during your [index] pregnancy?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy]
b. Month of pregnancy (B3-T3)
c. DK
d. RF

I4. From {second trimester start date} until the end of your pregnancy, did you take any medications to manage your diabetes and its complications?

a. YES → CONTINUE TO I5
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

I5. What medications did you take? /Did you take anything else? LIST ALL. IF CAN'T RECALL, READ FROM DRUG LIST. Did you take…?

a. Actos
b. Amaryl
c. Byetta
d. Diabeta
e. Diabinese
f. Glucophage
g. Glucotrol
h. Glucotrol XL
i. Glumetza
j. Glyburide
k. Glynase PresTab
l. Humalog
m. Humulin N
n. Humulin R
o. Januvia
p. Lantus
q. Levemir
r. Metformin HCL
s. Micronase
t. Novolin N
u. Novolin R
v. Novolog
w. Onglyza
x. Prandin
y. Precose
z. Starlix
aa. Victoza
bb. OTHER (SPECIFY)
cc. DK → SKIP TO NEXT SECTION
dd. RF →SKIP TO NEXT SECTION

I5a. How many different times did you take (Drug)? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

I6. When did you start using {medication} for diabetes the (1st ,2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or

b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

I7. When did you stop using {medication} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO I6 AND I7, SKIP I8
c. DK
d. RF

I8. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

I9. How often did you use {medication} the (1st, 2nd, etc.) time? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month
b. DK
c. RF

Section J. HIGH BLOOD PRESSURE

IF THE PARTICIPANT DID NOT REPORT A DIAGNOSIS OF HYPERTENSION [CORE CATI H28 = NO, DK, RF] → SKIP TO NEXT SECTION.

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF HYPERTENSION [CORE CATI H28 = YES] → READ:

In the previous interview, you told us that you had been diagnosed with high blood pressure in the past. Now I would like to ask some additional questions about your high blood pressure and any medications that you took to treat it from the beginning of your second trimester, that is from {second trimester start date}, until the end of your pregnancy.

J1. What type of high blood pressure did you or do you have? Was it **pregnancy-related** – that is during pregnancy only? Or is it **chronic high blood pressure or chronic hypertension**? This is high blood pressure that is **not related to your pregnancy**. This may have been diagnosed during pregnancy but did not go away after the pregnancy ended.

a. Pregnancy related → CONTINUE TO J2
b. Chronic high blood pressure → SKIP TO J4
c. Both → CONTINUE TO J2
d. DK → SKIP TO J4
e. RF → SKIP TO J4

J2. When did you have pregnancy-related high blood pressure? [READ LIST, a-c]

a. During a previous pregnancy only →IF J1 = BOTH → SKIP TO J4
IF J1 = PREGNANCY-RELATED → SKIP TO NEXT SECTION
b. During this [index] pregnancy only → CONTINUE TO J3
c. During this [index] pregnancy and a previous pregnancy → CONTINUE TO J3
d. DK → SKIP TO J4
e. RF → SKIP TO J4

J3. When was high blood pressure diagnosed during your [index] pregnancy?

a. Date _____
b. Month of pregnancy (B3-T3)
c. DK
d. RF

J4. From {second trimester start date} until the end of your pregnancy, did you take any medications or remedies for high blood pressure?

a. YES → CONTINUE TO J5
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

J5. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

a. Accupril
b. Adalat
c. Altace

d. Amlodipine
e. Atenolol
f. Avapro
g. Benazepril HCL
h. Benicar
i. Calan
j. Capoten
k. Cardizem
l. Covera -HS
m. Cozaar
n. Diltiazem HCL
o. Diovan
p. Enalapril Maleate
q. Hydralazine
r. Hydrochlorothiazide
s. Inderal
t. Irbesartan
u. Labetalol
v. Lisinopril
w. Losartan Potassium
x. Lotensin
y. Methyldopa
z. Metoprolol
aa. Microzide
bb. Nifedipine
cc. Normodyne
dd. Norvasc
ee. Olmesartan Medoxomil
ff. Prinivil
gg. Procardia
hh. Propranolol
ii. Quinapril HCL
jj. Ramipril
kk. Tenormin
ll. Tiazac
mm. Trandate
nn. Valsartan
oo. Vasotec
pp. Verapamil
qq. Verelan
rr. Zestril
ss. OTHER (SPECIFY):_____

tt. DK → SKIP TO NEXT SECTION
uu. RF → SKIP TO NEXT SECTION

J0. How many different times did you take (DRUG)? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

J6. When did you start using {medication} for high blood pressure the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

J7. When did you stop using {medication} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO J6 and J7, SKIP J8
c. DK
d. RF

J8. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

J9. How often did you use {medication} the (1st, 2nd, etc.) time? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

Section K. PREECLAMPSIA/ECLAMPSIA

K1. Did a doctor or other healthcare professional tell you that you had toxemia, pre-eclampsia, or eclampsia at any time during your [index] pregnancy?

a. Yes → CONTINUE TO K2
b. No → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

K2. Which condition(s) did you have? [READ ALL, RECORD ALL]

a. Toxemia/pre-eclampsia → CONTINUE TO K2a
b. Eclampsia → CONTINUE TO K2a
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

K2a. When was {condition} diagnosed?
(month of pregnancy, P1-P9, DK, RF) ____

K3. From {second trimester start date} until the end of your pregnancy, did you take any medications or remedies for {condition}?

a. Yes → CONTINUE TO K4
b. No → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

K4. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

a. Accupril
b. Adalat
c. Altace
d. Amlodipine
e. Atenolol
f. Avapro
g. Benazepril HCL
h. Benicar
i. Calan
j. Capoten
k. Cardizem
l. Covera -HS
m. Cozaar
n. Diltiazem HCL
o. Diovan
p. Enalapril Maleate
q. Hydralazine

r. Hydrochlorothiazide
s. Inderal
t. Irbesartan
u. Labetalol
v. Lisinopril
w. Losartan Potassium
x. Lotensin
y. Magnesium sulfate
z. Methyldopa
aa. Metoprolol
bb. Microzide
cc. Nicardipine
dd. Nifedipine
ee. Nitroprusside
ff. Normodyne
gg. Norvasc
hh. Olmesartan Medoxomil
ii. Prinivil
jj. Procardia
kk. Propranolol
ll. Quinapril HCL
mm. Ramipril
nn. Steroid
oo. Tenormin
pp. Tiazac
qq. Trandate
rr. Valsartan
ss. Vasotec
tt. Verapamil
uu. Verelan
vv. Zestril
ww. OTHER (SPECIFY):_____
xx. DK → SKIP TO NEXT SECTION
yy. RF → SKIP TO NEXT SECTION

K4a. How many different times did you take [DRUG]? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

K5. When did you start using {medication} for {specific condition(s)} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. ___ MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

K6. When did you stop using {medication} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO K5 and K6, SKIP K7
c. DK
d. RF

K7. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

K8. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

Section L. EPILEPSY/SEIZURES

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF EPILEPSY [CORE CATI K1 = NO, DK, RF OR K1 = YES AND K3 = AFTER THE PREGNANCY, DK, RF] → SKIP TO L11

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF EPILEPSY THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [CORE CATI K1 = YES AND K3 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY] → READ:

> In the previous interview, you told us that you had been diagnosed with epilepsy in the past. Now I would like to ask some questions specifically about your condition from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

L1. From {second trimester start date} until the end of your pregnancy, did you take any medications to treat your epilepsy?

a. YES → CONTINUE TO L2
b. NO → SKIP TO L9
c. DK → SKIP TO L9
d. RF → SKIP TO L9

L2. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

a. Carbamazepine
b. Carbatrol
c. Clonazepam
d. Depacon
e. Depakene Capsules
f. Depakote
g. Dilantin
h. Epitol
i. Equetro
j. Felbatol
k. Keppra
l. Klonopin
m. Lamictal
n. Lamotrigine
o. Phenobarbital
p. Phenytoin
q. Stavzor
r. Tegretol
s. Topamax
t. Topiramate
u. Trileptal
v. Valproic Acid
w. OTHER (SPECIFY)
x. DK → SKIP TO L9
y. RF → SKIP TO L9

L2a. How many different times did you take {medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

L3. When did you start using {medication} for epilepsy the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

L4. When did you stop using {medication} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO L3 and L4, SKIP L5
c. DK
d. RF

L5. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

L6. How often did you use {medication} the (1st, 2nd, etc.) time? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/ DK /RF

L9. From {second trimester start date} until the end of your pregnancy, did you have any seizures?

a. YES → CONTINUE TO L10
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

L10. How many seizures did you have altogether during that time?

a. AMOUNT:_____ → THEN SKIP TO NEXT SECTION
b. DK → SKIP TO NEXT SECTION
c. RF → SKIP TO NEXT SECTION

L11. At any time from the month before you became pregnant through the end of your pregnancy did you have any seizures?

a. YES → CONTINUE TO L12
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

L12. How many seizures did you have altogether during that time?

a. AMOUNT:_____
b. DK
c. RF

L13. At any time from the month before you became pregnant through the end of your pregnancy, did you take any medications to treat this condition or to prevent seizures?

a. YES → CONTINUE TO L14
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

L14. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST:

a. Carbamazepine
b. Carbatrol
c. Clonazepam
d. Depacon
e. Depakene Capsules
f. Depakote
g. Dilantin
h. Epitol
i. Equetro
j. Felbatol
k. Keppra
l. Klonopin
m. Lamictal
n. Lamotrigine
o. Phenobarbital
p. Phenytoin
q. Stavzor
r. Tegretol
s. Topamax
t. Topiramate
u. Trileptal

v. Valproic Acid
w. OTHER (SPECIFY)
x. DK → SKIP TO NEXT SECTION
y. RF → SKIP TO NEXT SECTION

L14a. How many different times did you take {medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

L15. When did you start using {medication} for epilepsy the (1st, 2nd, etc.) time?
a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

L16. When did you stop using {medication} the (1st, 2nd, etc.) time?
a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO L15 and L16, SKIP L17
c. DK
d. RF

L17. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?
a. AMOUNT:_____
i. Days
ii. Weeks
iii. Months
b. DK
c. RF

L18. How often did you use {medication} the (1st, 2nd, etc.) time? You can say the number of times per day, per week, or per month.
AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

Section M. MIGRAINE

IF THE PARTICIPANT DID NOT REPORT MIGRAINES PREVIOUSLY [CORE CATI L1 = NO, DK, RF] → SKIP TO NEXT SECTION

IF THE PARTICIPANT REPORTED MIGRAINES PREVIOUSLY [CORE CATI L1 = YES] → READ:

In the previous interview, you told us that you have had migraines in the past. Now I would like to ask you some questions about your condition from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

M1. From {second trimester start date} until the end of your pregnancy, did you have any migraines?

a. YES → CONTINUE TO M2
b. NO → SKIP TO M3
c. DK → SKIP TO M3
d. RF → SKIP TO M3

M2. From {second trimester start date} until the end of your pregnancy, how frequent were your migraines?

a. Frequency – AMOUNT:_____
   i. Per day
   ii. Per week
   iii. Per month
   iv. Per time period
b. DK
c. RF

M3. Now I am going to ask about maintenance medications and remedies you may use for your migraines. Please include medications that you may use to keep from having or to prevent migraines AND medications that you may use to treat migraine pain when it happens. Please include over-the-counter medications and prescription medications.

From {second trimester start date} until the end of your pregnancy, did you take any medications or remedies for migraines?

a. YES → CONTINUE TO M4
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

M4. What did you take? / Did you take anything else? IF CAN'T RECALL: Was this a medication you used to prevent a migraine from starting or to treat pain from a migraine that already started? IF

IT WAS PAIN MEDICATION: Was this over-the-counter or prescription? THEN READ FROM THE APPROPRIATE DRUG LIST:

PREVENTION MEDICATIONS

a. Advil
b. Aleve
c. Amitriptyline
d. Aspirin
e. Atenolol
f. Botox
g. Calan
h. Carbamazepine
i. Carbatrol
j. Cyproheptadine HCL
k. Depacon
l. Depakene
m. Depakote
n. Diltiazem
o. Divalproex Sodium
p. Doxepin
q. Effexor
r. Epitol
s. Equetro
t. Excedrin Extra Strength Caplets/Tablets/Geltabs
u. Gabapentin
v. Ibuprofen
w. Inderal
x. Innopran XL
y. Lamictal
z. Lamotrigine
aa. Lisinopril
bb. Metoprolol
cc. Motrin
dd. Motrin Ib
ee. Nadolol
ff. Naproxen Sodium
gg. Neurontin
hh. Nifedipine
ii. Nimodipine
jj. Nortriptyline
kk. Pamelor

ll. Propranolol
mm. Protriptyline HCL
nn. Tegretol
oo. Timolol
pp. Topamax
qq. Topiramate
rr. Valproate Sodium
ss. Valproic Acid
tt. Venlafaxine
uu. Verapamil
vv. Verelan
ww. Vivactil
xx. Zestril

OVER-THE-COUNTER PAIN MEDICATIONS

yy. Acetaminophen
zz. Advil
aaa. Aleve
bbb. Aspirin
ccc. Excedrin Migraine
ddd. Ibuprofen
eee. Motrin
fff. Naproxen Sodium
ggg. Tylenol

PRESCRIPTION PAIN MEDICATIONS

hhh. Acetaminophen with Codeine
iii. Almotriptan Maleate
jjj. Amerge
kkk. Axert
lll. Cafergot
mmm. Dihydroergotamine
nnn. Eletriptan Hydrobromide
ooo. Ergotamine
ppp. Fioricet
qqq. Frova
rrr. Frovatriptan Succinate
sss. Imitrex
ttt. Indomethacin
uuu. Maxalt
vvv. Migergot Suppositories

www. Migranal
xxx. Naproxen Sodium / Sumatriptan Succinate
yyy. Naratriptan
zzz. Relpax
aaaa. Rizatriptan
bbbb. Sumatriptan Succinate
cccc. Treximet
dddd. Zolmitriptan
eeee. Zomig
ffff. OTHER (SPECIFY):_____
gggg. DK → SKIP TO NEXT SECTION
hhhh. RF → SKIP TO NEXT SECTION

M4a. How many different times did you take {medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

M5. When did you start using {medication} for migraines for the [1st, 2nd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

M6. When did you stop using {medication} for the [1st, 2nd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO M5 and M6, SKIP M7
c. DK
d. RF

M7. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

M8. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

Section N. DEPRESSION / ANXIETY

IF THE PARTICIPANT DID NOT REPORT A DIAGNOSIS OF ANXIETY OR DEPRESSION BEFORE THE END OF THE INDEX PREGNANCY [CORE CATI O1 = NO, DK, RF AND O4= NO, DK, RF
OR
CORE CATI O1 = NO, DK, RF AND O4 = YES AND O5= AFTER THE PREGNANCY
OR
CORE CATI O1= YES AND O3 = AFTER THE PREGNANCY AND O4= NO, DK, RF
OR
CORE CATI O1= YES AND O3 = AFTER THE PREGNANCY AND O4 = YES AND O5= AFTER THE PREGNANCY]
→SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF ANXIETY OR DEPRESSION THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [CORE CATI O1 = YES AND O3 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY
AND/ OR
O4 =YES AND O5= MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY]
→ READ:

In the previous interview, you told us that you were diagnosed in the past *with depression* [IF CORE CATI O4 = YES] / {*anxiety condition from O2*} [IF O1 = YES]. Now I would like to ask you about your condition from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

N1. Did you experience any symptoms from {second trimester start date}, until the end of your pregnancy?

a. YES → CONTINUE TO N2
b. NO → SKIP TO N3
c. DK → SKIP TO N3
d. RF → SKIP TO N3

N2. What were the symptoms you experienced?

a. Specify: _____ DK RF

N3. From {second trimester start date} until the end of your pregnancy, did you use any medications to treat your condition?

a. YES → CONTINUE TO N4
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

N4. What did you take? / Did you take anything else? IF CAN'T RECALL, READ FROM DRUG LIST

a. Abilify
b. Alprazolam
c. Anafranil
d. Aripiprazole
e. Ativan
f. Bupropion
g. Buspar
h. Buspirone
i. Carbamazepine
j. Carbatrol
k. Celexa
l. Citalopram Hydrobromide
m. Clomipramine
n. Clonazepam
o. Cymbalta
p. Depacon
q. Depakene
r. Depakote
s. Diazepam
t. Duloxetine HCL
u. Effexor
v. Epitol
w. Equetro
x. Escitalopram Oxolate
y. Fluoxetine HCL
z. Imipramine
aa. Inderal
bb. Klonopin
cc. Lamictal
dd. Lamotrigine
ee. Lexapro
ff. Lorazepam

gg. Paroxetine HCL
hh. Paxil
ii. Propranolol
jj. Prozac
kk. Sertraline HCL
ll. St. John's Wort
mm. Tegretol
nn. Tofranil
oo. Valium
pp. Valproic acid
qq. Venlafaxine
rr. Wellbutrin
ss. Xanax
tt. Zoloft
uu. OTHER (SPECIFY):_____
vv. DK → SKIP TO NEXT SECTION
ww. RF → SKIP TO NEXT SECTION

N4a. How many different times did you take {medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

N5. When did you start using {medication} for your condition for the [1st, 2nd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

N6. When did you stop using {medication} for the [1st, 2nd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO N5 AND N6, SKIP N7
c. DK
d. RF

N7. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
i. Days

ii. Weeks
iii. Months

b. DK
c. RF

N8. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

Section O. BLEEDING/CLOTTING DISORDERS

O1. Did a doctor or other healthcare provider ever tell you that had a bleeding disorder or a clotting disorder?

a. YES → CONTINUE TO O2
b. NO → SKIP TO O7
c. DK → SKIP TO O7
d. RF → SKIP TO O7

O2. What was the name of the bleeding or clotting disorder?

a. _____ (specify)
b. DK
c. RF

O3. When were you diagnosed with this condition?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or_____(Age in years)
b. DK
c. RF

O4. At any time during your pregnancy, did you have any complications from this condition, for example, significant bleeding or a blood clot?

a. YES → CONTINUE TO O5
b. NO → SKIP TO O7
c. DK → SKIP TO O7
d. RF → SKIP TO O7

O5a. How many times did you have complications? (IF THEY DON'T KNOW, ENTER 1)

a. NUMBER _____

O5. What were the complications the [1st, 2nd, etc] time you had complications?

a. _____ (specify)
b. DK
c. RF

O6a. When did it occur?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] OR
b. ___ MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

O7. At any time during your pregnancy, did you take any medications or receive any treatments for a bleeding or clotting disorder? Please include anything you may have taken to prevent a problem.

a. YES → CONTINUE TO O8
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

O8. What did you take? / Did you take anything else?

a. SPECIFY:_____
b. DK → SKIP TO NEXT SECTION
c. RF → SKIP TO NEXT SECTION

O8a. How many different times did you take {medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

O9. When did you start using {medication} for your condition the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (P1, P2, P3, P4, P5, P6, P7, P8, P9)
c. DK
d. RF

O10. When did you stop using {medication} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (P1, P2, P3, P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO O9 and O10, SKIP O11
c. DK
d. RF

O11. OR, From {second trimester} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

O12. How often did you take {medication} the (1st, 2nd, etc.) time? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

Section P. AUTOIMMUNE DISEASE

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF AN AUTOIMMUNE DISEASE [CORE CATI M1 = NONE, DK, RF OR M1 = YES AND M2 = AFTER THE PREGNANCY] → SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF AN AUTOIMMUNE DISEASE THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [CORE CATI M1 = YES AND M2 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY] → READ:

In the previous interview, you told us that you were diagnosed in the past with {specific condition(s) from M1}. Now I would like to ask you about your condition(s) from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy.

ASK THESE QUESTIONS FOR EACH CONDITION GIVEN IN CORE CATI M1

P1. From {second trimester start date} until the end of your pregnancy, did you take any medications to treat {specific condition}?

a. YES → CONTINUE TO P2
b. NO → SKIP TO NEXT CONDITION OR IF NONE, TO NEXT SECTION

c. DK → SKIP TO NEXT CONDITION OR IF NONE, TO NEXT SECTION
d. RF → SKIP TO NEXT CONDITION OR IF NONE, TO NEXT SECTION

P2. What did you take? / Did you take anything else? SPECIFY: _____
IF CAN'T RECALL, READ FROM DRUG PROMPT LISTS FOR THESE 4 CONDITIONS, BUT DRUGS ASKED FOR EACH CONDITION.

Lupus:

a. Advil
b. Aleve
c. Arava
d. Azasan
e. Azathioprine
f. Belimumab
g. Benlysta
h. Cellcept
i. Cyclophosphamide
j. Cytoxan
k. Hydroxychloroquine Sulfate
l. Leflunomide
m. Methotrexate
n. Motrin
o. Mycophenolate Mofetil
p. Plaquenil
q. Prednisone
r. Trexall
s. OTHER, SPECIFY:_____
t. DK → SKIP TO NEXT CONDITION/NEXT SECTION
u. RF → SKIP TO NEXT CONDITION/NEXT SECTION

Rheumatoid arthritis:

a. Abatacept
b. Actemra
c. Adalimumab
d. Advil
e. Aleve
f. Anakinra
g. Arava
h. Azasan
i. Azathioprine
j. Azulfidine
k. Certolizumab Pegol

l. Cimzia
m. Cyclophosphamide
n. Cyclosporine
o. Cytoxan
p. Dynacin
q. Enbrel
r. Etanercept
s. Gengraf
t. Golimumab
u. Humira
v. Hydroxychloroquine Sulfate
w. Ibuprofen
x. Imuran
y. Infliximab
z. Kineret
aa. Leflunomide
bb. Methotrexate
cc. Minocin
dd. Minocycline
ee. Motrin
ff. Naproxen Sodium
gg. Neoral
hh. Orencia
ii. Plaquenil
jj. Prednisone
kk. Remicade
ll. Rituxan
mm. Rituximab
nn. Sandimmune
oo. Simponi
pp. Sulfasalazine
qq. Tocilizumab
rr. Trexall
ss. OTHER, SPECIFY:_____
tt. DK → SKIP TO NEXT CONDITION/NEXT SECTION
uu. RF → SKIP TO NEXT CONDITION/NEXT SECTION

Multiple sclerosis:

a. Amantadine
b. Ampyra
c. Amrix
d. Aubagio

e. Avonex
f. Baclofen
g. Betaseron
h. Copaxone
i. Cyclobenzaprine
j. Dalfampridine
k. Extavia
l. Fingolimod
m. Flexeril
n. Gilenya
o. Glatiramer Acetate
p. Lioresal
q. Methylprednisolone
r. Mitoxantrone HCL
s. Natalizumab
t. Prednisone
u. Rebif
v. Solu-Medrol
w. Tecfidera
x. Teriflunomide
y. Tizanidine HCL
z. Tysabri
aa. Zanaflex
bb. OTHER, SPECIFY:_____
cc. DK → SKIP TO NEXT CONDITION/NEXT SECTION
dd. RF → SKIP TO NEXT CONDITION/NEXT SECTION

Crohn's disease and ulcerative colitis:

a. Adalimumab
b. Apriso
c. Asacol
d. Azasan
e. Azathioprine
f. Azulfidine
g. Balsalazide Disodium
h. Certolizumab Pegol
i. Cimzia
j. Cipro
k. Ciprofloxacin
l. Colazal
m. Cyclosporine
n. Dipentum
o. Flagyl

p. Gengraf
q. Humira
r. Imuran
s. Infliximab
t. Lialda
u. Mercaptopurine
v. Mesalamine
w. Methotrexate
x. Metronidazole
y. Natalizumab
z. Neoral
aa. Olsalazine Sodium
bb. Purinethol
cc. Remicade
dd. Rheumatrex
ee. Sandimmune
ff. Sulfasalazine
gg. Tysabri
hh. OTHER (SPECIFY):_____
ii. DK → SKIP TO NEXT CONDITION/NEXT SECTION
jj. RF → SKIP TO NEXT CONDITION/NEXT SECTION

Psoriasis:

a. Anthralin
b. Calcipotriene
c. Coal Tar
d. Dovonex
e. Elidel
f. Protopic Ointment
g. Retin-A
h. Salicylic Acid
i. Tazorac
j. Tazarotene
k. Tretinoin
l. OTHER (SPECIFY):_____
m. DK → SKIP TO NEXT CONDITION/NEXT SECTION
n. RF → SKIP TO NEXT CONDITION/NEXT SECTION

P2a. How many different times did you take {CONDITION - medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

P3. When did you start using {medication} for {specific condition} for the [1st, 2nd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

P4. When did you stop using {medication} for the [1st, 2nd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO P3 AND P4, SKIP P5
c. DK
d. RF

P5. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

P6. How often did you use {medication} during this time period? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/DK/RF

P7. Did you use {medication} at any other time from {second trimester start date} until the end of your pregnancy?

a. YES → RETURN TO P3, RECORD ADDITIONAL DATES AND FREQUENCY OF USE INFORMATION, AND THEN CONTINUE TO P8
b. NO → CONTINUE TO P8

P8. Did you take anything else for this condition?

a. YES → RETURN TO P2
b. NO → CONTINUE TO NEXT CONDITION OR IF NONE, TO NEXT SECTION

Section Q. FEVER

Q1. From the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy, did you have any fevers, including those due to respiratory illness, bronchitis, pneumonia, a kidney, bladder, or urinary tract infection, pelvic inflammatory disease, or other infections or illness?

a. YES → CONTINUE TO Q2
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

Q2. From {second trimester start date} until the end of your pregnancy, how many fevers do you remember having? IF DON'T KNOW OR REFUSE NUMBER, ENTER 1.

a. NUMBER:_____

Q3. What was the cause of the {first, then second, etc.} fever?

a. CAUSE:_____
b. DK
c. RF

Q4. When you had {cause}, during which of those months did you have a fever?

a. P4
b. P5
c. P6
d. P7
e. P8
f. P9
g. DK
h. RF

Q5. What was the highest temperature recorded during your fever?

a. VALUE:_____
    i. UNITS: F or C _____
b. DK
c. RF
d. NOT RECORDED

Q6. Did you take any medications or remedies for this fever?

a. YES → CONTINUE TO Q7

b. NO → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED → SKIP TO NEXT SECTION
c. DK → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION
d. RF → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION

Q7. What did you take? Did you take anything else? CODE ALL THAT APPLY. IF CAN'T RECALL, READ FROM DRUG LIST: Did you take…?

a. Acetaminophen
b. Advil
c. Aleve
d. Ibuprofen
e. Motrin
f. Naproxen sodium
g. Nuprin
h. Tylenol
i. OTHER (SPECIFY):_____
j. DK → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION
k. RF → RETURN TO Q3 AND ASK ABOUT NEXT EPISODE OF FEVER. IF ALL EPISODES HAVE BEEN COVERED SKIP TO NEXT SECTION

Q7a. How many different times did you take {medicine}? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

Q8. When did you start using {medication} for this fever the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9)
c. DK
d. RF

Q9. When did you stop using {medication} for this fever the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (P4, P5, P6, P7, P8, P9) → IF VALID RESPONSE TO Q8 and Q9, SKIP Q10
c. DK
d. RF

Q10. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

Q11. How often did you use {medication} for this fever? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/Per Time Period/DK/RF

WHEN ALL FEVER EPISODES HAVE BEEN COVERED → CONTINUE TO NEXT SECTION

Section R. ASTHMA

IF THE PARTICIPANT DID NOT REPORT A PREVIOUS DIAGNOSIS OF ASTHMA [CORE CATI J1 = NO, DK, RF OR J1 = YES AND J2 = AFTER THE PREGNANCY] → SKIP TO NEXT SECTION

IF THE PARTICIPANT PREVIOUSLY REPORTED A DIAGNOSIS OF ASTHMA THAT OCCURRED BEFORE THE END OF THE INDEX PREGNANCY [CORE CATI J1 = YES AND J2 = MORE THAN 2 YEARS BEFORE (PREGNANCY), IN THE 2 YEARS BEFORE, DURING THE FIRST TRIMESTER, AFTER THE FIRST TRIMESTER BUT STILL DURING PREGNANCY] → READ:

> In the previous interview, you told us that you were diagnosed in the past with asthma. Now I would like to ask you some additional questions about your asthma. In these questions, I am referring to your pregnancy *with {name of infant}* (for liveborns)/ *that ended on {pregnancy end date}* (for stillbirths).

R1. At any time **during the year before you became pregnant** were you hospitalized overnight because of your asthma?

a. YES → CONTINUE TO R1a
b. NO → SKIP TO R1c
c. DK → SKIP TO R1c
d. RF → SKIP TO R1c

R1a. How many times were you hospitalized? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)
a. NUMBER _____

R1b. When were you hospitalized the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/ dd /yyyy], DK RF

R1c. At any time **during the year before you became pregnant** did you go to an emergency room for increased asthma symptoms (but did not require hospitalization)?

a. YES → CONTINUE TO R1d
b. NO → SKIP TO R1f
c. DK → SKIP TO R1f
d. RF → SKIP TO R1f

R1d. How many times did you go to an emergency room? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R1e. When did you go to an emergency room the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/ dd /yyyy], DK RF

R1f. At any time **during the year before you became pregnant** did you have to make an urgent visit to a physician or clinic for increased asthma symptoms (other than what we discussed)?

a. YES → CONTINUE TO R1g
b. NO → SKIP TO R1i
c. DK → SKIP TO R1i
d. RF → SKIP TO R1i

R1g. How many times did you make an urgent visit to a physician or clinic? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R1h. When did you make the urgent visit the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/ dd /yyyy], DK RF

R1i. Were you given steroids (ex. Prednisone) as tablet, injection or IV?

a. YES → CONTINUE TO R1j
b. NO → SKIP TO R2
c. DK → SKIP TO R2
d. RF → SKIP TO R2

Rij. How many times were you given steroids? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R1k. When were you given steroids the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/ dd /yyyy], DK RF

And now some more questions about **the year before you became pregnant**.

R2. How much of the time did your asthma interfere with getting your work done at home or on the job? [READ LIST]

a. NEVER
b. SOMETIMES
c. OFTEN
d. CONSTANTLY
e. DK
f. RF

R2b. How often did you have shortness of breath due to your asthma?

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R2c. How often did your asthma wake you up at night or earlier than usual in the morning?

a. _____ Number of times per day , per week, per month, per year, Never, DK, RF

R2d. How often did you use an inhaler for immediate relief of asthma symptoms?

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R2e. How would you rate your asthma control? [READ LIST]

a. COMPLETELY CONTROLLED
b. WELL CONTROLLED
c. SOMEWHAT CONTROLLED

d. POORLY CONTROLLED
e. NOT AT ALL CONTROLLED
e. DK
f. RF

R3. The next questions are about your asthma **during your pregnancy**. At any time **during your pregnancy** were you hospitalized overnight because of your asthma?

a. YES → CONTINUE TO R3b
b. NO → SKIP TO R3c
c. DK → SKIP TO R3c
d. RF → SKIP TO R3c

R3a. How many times were you hospitalized? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R3b. When were you hospitalized the (1st, 2nd, etc.) time?

a. _____ Date, B3-T3, DK, RF

R3c. At any time **during your pregnancy** did you go to an emergency room for increased asthma symptoms (but did not require hospitalization)?

a. YES → CONTINUE TO R3d
b. NO → SKIP TO R3f
c. DK → SKIP TO R3f
d. RF → SKIP TO R3f

R3d. How many times did you go to an emergency room? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R3e. When did you go to an emergency room the (1st, 2nd, etc.) time?

a. _____ Date, B3-T3, DK, RF

R3f. At any time **during your pregnancy** did you have to make an urgent visit to a physician or clinic for increased asthma symptoms (other than the above)?

a. YES → CONTINUE TO R3g
b. NO → SKIP TO R3i

c. DK → SKIP TO R3i
d. RF → SKIP TO R3i

R3g. How many times did you make an urgent visit to a physician or clinic? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R3h. When did you make the urgent visit the (1st, 2nd, etc.) time?

a. _____ Date, B3-T3, DK, RF

R3i. At any time **during your pregnancy** were you given steroids (ex. Prednisone) as tablet, injection or IV?

a. YES → CONTINUE TO R3j
b. NO → SKIP TO R4a
c. DK → SKIP TO R4a
d. RF → SKIP TO R4a

R3j. How many times were you given steroids? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R3k. When were you given steroids the (1st, 2nd, etc.) time?

a. _____ Date, B3-T3, DK, RF

R4a. The next questions are about your asthma during the **first trimester** of your pregnancy. During **the first trimester of your pregnancy** how much of the time did your asthma interfere with getting your work done at home or on the job? [READ LIST]

a. NEVER
b. SOMETIMES
c. OFTEN
d. CONSTANTLY
e. DK
f. RF

R4b. How often did you have shortness of breath due to your asthma?

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R4c. How often did your asthma wake you up at night or earlier than usual in the morning? Again, we want to know about the first trimester of your pregnancy.

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R4d. How often did you use an inhaler for immediate relief of asthma symptoms?

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R4e. How would you rate your asthma control? Again, we want to know about the first trimester of your pregnancy. [READ LIST]

a. COMPLETELY CONTROLLED
b. WELL CONTROLLED
c. SOMEWHAT CONTROLLED
d. POORLY CONTROLLED
e. NOT AT ALL CONTROLLED
f. DK
g. RF

R5a. Next we'd like to ask about your asthma from the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy. **During that time period,** how much of the time did your asthma interfere with getting your work done at home or on the job? [READ LIST]

a. NEVER
b. SOMETIMES
c. OFTEN
d. CONSTANTLY
e. DK
f. RF

R5b. How often did you have shortness of breath due to your asthma?

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R5c. How often did your asthma wake you up at night or earlier than usual in the morning? Again, now we want to know about the time from the beginning of your second trimester until the end of your pregnancy.

a._____ Number of times per day, per week, per month, per year, Never, DK, RF

R5d. How often did you use an inhaler for immediate relief of asthma symptoms?

a. _____ Number of times per day, per week, per month, per year, Never, DK, RF

R5e. How would you rate your asthma control? Again, now we want to know about the time from the beginning of your second trimester until the end of your pregnancy. [READ LIST]

a. COMPLETELY CONTROLLED
b. WELL CONTROLLED
c. SOMEWHAT CONTROLLED
d. POORLY CONTROLLED
e. NOT AT ALL CONTROLLED
f. DK
g. RF

R6. Finally, from {second trimester start date} until the end of your pregnancy, did you take any medications for your asthma? Please tell me about maintenance medications and remedies you may take for long-term control of your asthma and fast-acting, or "rescue", medications you may take for treatment of an asthma attack.

a. YES → CONTINUE TO R7
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

R7. What did you take? / Did you take anything else?

NASAL SPRAYS

a. Flonase
b. Flunisolide
c. Fluticasone Nasal Spray
d. Nasonex Nasal Spray
e. Omnaris Nasal Spray
f. Qnasl Nasal Aerosol
g. Rhinocort
h. OTHER (SPECIFY):_____

ORAL INHALANTS

i. Advair
j. Aerobid
k. Aerospan Hfa
l. Alvesco Inhaler
m. Asmanex Twisthaler
n. Budesonide Inhalation Suspension
o. Dulera
p. Flovent
q. Foradil
r. Formoterol Fumarate
s. Perforomist
t. Pulmicort
u. Qvar HFA Inhaler
v. Salmeterol Xinafoate
w. Serevent
x. Symbicort
y. OTHER (SPECIFY):_____

ORAL TABLETS/CAPS

z. Accolate
aa. Montelukast Sodium
bb. Singulair
cc. Zafirlukast
dd. Zileuton
ee. Zyflo
ff. OTHER (SPECIFY):_____

FAST ACTING OR "RESCUE" MEDICATIONS

gg. Albuterol
hh. Asthmanefrin
ii. Atrovent HFA
jj. Ipratropium Bromide
kk. Levalbuterol Tartrate
ll. Maxair
mm. Pirbuterol Acetate
nn. ProAir HFA Inhaler
oo. Ventolin HFA
pp. Xopenex HFA
qq. OTHER (SPECIFY):_____

DON'T KNOW/REFUSED

rr. DK→ SKIP TO NEXT SECTION
ss. RF→ SKIP TO NEXT SECTION

R7a. How many different times did you take [DRUG CATEGORY - medication]? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

R8. When did you start using {medication} for asthma the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3)
c. DK
d. RF

R9. When did you stop using {medication} the (1st, 2nd, etc.) time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd /yyyy] or
b. MONTH OF PREGNANCY (B3-T3) → IF VALID RESPONSE TO R8 and R9, SKIP R10
c. DK
d. RF

R10. OR, From {second trimester start date} until the end of your pregnancy, how long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

R11. How often did you use {medication} the (1st, 2nd, etc.) time? You can say the number of times per day, per week, or per month.

a. AMOUNT:_____ Per Day/Per Week/Per Month/ DK /RF

Section S. INJURY

S1. From the beginning of your second trimester, {second trimester start date}, until the end of your pregnancy, did you have physical harm to your body due to injury, abuse, or crime?

a. YES → CONTINUE TO S2
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

S2. Did you seek medical care for this injury?

a. YES → CONTINUE TO S3
b. NO → SKIP TO NEXT SECTION
c. DK → SKIP TO NEXT SECTION
d. RF → SKIP TO NEXT SECTION

S3. Were you hospitalized?

a. YES
b. NO
c. DK
d. RF

Section T. SPECIFIC MEDICATION EXPOSURES

T1. Now I'm going to read you a list of specific medications. You may have already told me about some of these medications in the earlier questions, so please remind me if I repeat something. Please let me know if you have taken any of these medications from {second trimester start date} until the end of your pregnancy.

T1a. Pre-natal vitamins → If YES,

T1a1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1a2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1a3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters

b. DK
c. RF

T1b. Folic acid → If YES,

T1b1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1b2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1b3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1c. Alka-seltzer → If YES

T1c1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1c2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1c3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1d. Pepto bismol → If YES,

T1d1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1d2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1d3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1e. Aspirin → If YES

T1e1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1e2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1e3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1f. Aleve/Naprosyn/naproxen → If YES

T1f1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1f2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1f3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1g. Advil/Motrin/ibuprofen → If YES

T1g1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

F

T1g2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T OR DK, RF

T1g3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1h. Tylenol/acetaminophen

T1h1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1h2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1h3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1i. Sudafed/pseudoephedrine → If YES

T1i1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1i2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1i3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1j. Afrin/oxymetazoline → If YES

T1j1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1j2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1j3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days

ii. Weeks
iii. Months
iv. Trimesters

b. DK
c. RF

T1k. Neosynephrine/phenylephrine → If YES

T1k1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1k2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1k3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
i. Days
ii. Weeks
iii. Months
iv. Trimesters

b. DK
c. RF

T1l. Adderall → If YES

T1l1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1l2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1l3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
i. Days
ii. Weeks
iii. Months
iv. Trimesters

b. DK

c. RF

T1m. Concerta/Ritalin/methylphenidate → If YES

T1m1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1m2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1m3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1n. Strattera/atomoxetine → If YES

T1n1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1n2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1n3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1o. Vyvanse/lisdexamfetamine → If YES

T1o1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1o2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1o3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1p. Amphetamines, methamphetamine, cocaine, crack? → If YES

T1p1. Start date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1p2. Stop date:

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

T1p3. OR, How long did you take it? (IF VALID RESPONSE TO T1a1 and T1a2, SKIP T1a3)

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
   iv. Trimesters
b. DK
c. RF

T1q. Any other medications used in this time period? → If YES, specify all:

T2. What did you take? / Anything else?

_____Medication, DK, RF

T4a. How many different times did you take [1st, 2nd, etc, MEDICATION]? (IF THEY DON'T KNOW OR REFUSE, ENTER 1)

a. NUMBER _____

T4b. When did you start using [MEDICATION] the [1st, 2nd, 3rd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

When did you stop using [MEDICATION] the [1st, 2nd, 3rd, etc] time?

a. __ __ /__ __ /__ __ __ __ date [mm/dd/yyyy] OR B3-T3 OR DK, RF

(IF VALID RESPONSE TO START AND STOP DATES, SKIP TO NEXT SECTION)

To. OR, How long did you take it?

a. AMOUNT:_____
   i. Days
   ii. Weeks
   iii. Months
b. DK
c. RF

Section U: OTHER QUESTIONS

U1. Do you have any thoughts or ideas about what may cause stillbirths? [ASK OPEN-ENDED]

_____

_____DK, RF

FINAL REMARK

In closing, we would like to sincerely thank you for your time and efforts. Your contribution to this important study will help us greatly in our work to better understand the causes of poor pregnancy outcomes. Thank you!