Entered: _ _ / _ _ / 20_ _ Initials: _____ Verified: _ _ / _ _ /20 _ _ Initials: _____
mm dd yy mm dd yy

Patient ID __ __ __ - __ __ __ __ - __ __ **ID** **Visit:** **VISIT**

For office use only.

Reproductive Health Pregnancy Questionnaire (RHP) – Version: 01/01/2010 **FORMV**

Form Completion Date __ __ / __ __ / 20 __ __ **RHPDAT** **Pregnancy #** **PREGNUM**
mm dd yy

Instructions: Please complete a Pregnancy Questionnaire for each pregnancy that **ENDED in the past 12 months**. To identify each pregnancy please start by providing important dates. If you do not know the exact date, please write your best guess for the month and year.

CONCM / CONCD / CONCY

1. What is the date (or month and year) you conceived (became pregnant)? __ __ / __ __ / 20 __ __
mm dd yy

DUEM / DUED / DUEY

2. What was your due date? __ __ / __ __ / 20 __ __
mm dd yy

3. What was the outcome of your pregnancy and the date of that outcome?

POUTLBM / POUTLBD / POUTLBY

POUTLB ☐ 1. Live birth → delivery date: __ __ / __ __ / 20 __ __
mm dd yy

POUTSBM / POUTSBD / POUTSBY

POUTSB ☐ 2. Still birth (baby lost after 20 weeks or 5 months) → delivery date: __ __ / __ __ / 20 __ __
mm dd yy

POUTE ☐ 3. Ectopic or tubal pregnancy → date pregnancy ended: __ __ / __ __ / 20 __ __ **POUTEM / POUTED / POUTEY**
mm dd yy

POUTMM / POUTMD / POUTMY

POUTMC ☐ 4. Miscarriage (fetus lost before 20 weeks or 5 months) → date of miscarriage: __ __ / __ __ / 20 __ __
mm dd yy

POUTAM / POUTAD / POUTAY

POUTA ☐ 5. Abortion → date of abortion: __ __ / __ __ / 20 __ __
mm dd yy

4. Do you remember how many weeks pregnant you were when your pregnancy ended?
PWEEKS
☐ 0. No → 4.1 Please estimate in months, how long you were pregnant: _____ (months) **PWEEKSN**
☐ 1. Yes → 4.2 How many weeks were you pregnant? _____ (weeks) **PWEEKSY**

Please answer all questions on this form with regards to this pregnancy only.

FETUSES

5. With how many fetuses (babies) were you pregnant?
☐ 1 (singleton) ☐ 4 (quadruplets)
☐ 2 (twins) ☐ 5 or more
☐ 3 (triplets)

PWGHT

6. Do you remember how much you weighed when you became pregnant?
PWGHTN
☐ 0. No → 6.1 Please make your best guess of how much you weighed when you became pregnant: _____ pounds
☐ 1. Yes → 6.2 How much did you weigh when you became pregnant? _____ pounds **PWGHTY**

PWTGAIN

7. Do you remember how much weight you gained (or lost) during your pregnancy?
☐ 0. No → 7.1 Please provide your best guess of how many pounds
PWTGAINN you gained/lost: _____ pounds (*if lost weight, write a minus '-' sign in front of # pounds*)

☐ 1. Yes → 7.2 How many pounds did
PWTGAINY you gain/lose? _____ pounds (*if lost weight, write a minus '-' sign in front of # pounds*)

8. Were you on fertility treatment when you became pregnant?
   - ☐ 0. No → *skip to Q9* **FTBP**
   - ☐ 1. Yes ↓

   8.1 Do you know what fertility treatments you received?
   - ☐ -3. Not Sure → *skip to Q9* **FTBPR**
   - ☐ 0. No → *skip to Q9*
   - ☐ 1. Yes ↓

   8.1.1 Please check "No" or "Yes" for each item:

No	Yes		
☐	☐	Clomiphene Citrate (Clomid)	**FTBPRCC**
☐	☐	Metformin (Glucophage)	**FTBPRM**
☐	☐	Letrozole (Femara)	**FTBPRL**
☐	☐	Injectable FSH Medications (e.g., Gonal-F, Follistim)	**FTBPRFSH**
☐	☐	Intrauterine Insemination	**FTBPRII**
☐	☐	In Vitro Fertilization	**FTBPRIVF**
☐	☐	Other (Specify: _____)	**FTBPRO** **FTBPROS**

9. Did you receive prenatal care (medical care to follow the progress of your pregnancy)?
   - ☐ 0. No **PNATAL**
   - ☐ 1. Yes

10. Did you have severe vomiting that required medication or hospitalization during your pregnancy?
    - ☐ -3. Not Sure → *skip to Q11* **SEVVOM**
    - ☐ 0. No → *skip to Q11*
    - ☐ 1. Yes ↓

    10.1. Were you hospitalized for vomiting?
    - ☐ 0. No **SEVVOMH**
    - ☐ 1. Yes

11. Did you have pre-eclampsia or toxemia (protein in your urine and high blood pressure) during your pregnancy?
    - ☐ -3. Not Sure → *skip to Q12* **PREECL**
    - ☐ 0. No → *skip to Q12*
    - ☐ 1. Yes ↓

    11.1 Were you hospitalized for pre-eclampsia during your pregnancy?
    - ☐ -3. Not Sure **PREECLH**
    - ☐ 0. No
    - ☐ 1. Yes

    11.2 Did you receive magnesium sulfate (a medication given to women with pre-eclampsia during labor to prevent seizures)?
    - ☐ -3. Not Sure **PREECLMS**
    - ☐ 0. No
    - ☐ 1. Yes

12. Did you have gestational diabetes (diabetes diagnosed only during pregnancy) during your pregnancy?
- ☐ -3. Not Sure → *skip to Q13* **GDIAB**
- ☐ 0. No → *skip to Q13*
- ☐ 1. Yes ↓

12.1. Were you hospitalized for gestational diabetes during your pregnancy?
- ☐ -3. Not Sure **GDIABH**
- ☐ 0. No
- ☐ 1. Yes

12.2. Did you receive treatment for gestational diabetes during your pregnancy?
- ☐ 0. No → *skip to Q13* **GDIABT**
- ☐ 1. Yes ↓

12.2.1 Please check "No" or "Yes" for each treatment.

No	Yes		
☐	☐	a. Diet	**GDIABTD**
☐	☐	b. Oral medication	**GDIABTOM**
☐	☐	c. Insulin	**GDIABTI**
☐	☐	d. Other (Specify: _____)	**GDIABTO** **GDIABTOS**

13. Did you have surgery during your pregnancy other than a c-section?
- ☐ 0. No → *skip to Q14*
- ☐ 1. Yes ↓ **SDP**

13.1 Please check "No" or "Yes" to indicate which surgical procedures you had during your pregnancy:

No	Yes		
☐	☐	Cerclage (placement of stitches in the cervix to hold it closed)	**SDPC**
☐	☐	Oophorectomy (ovary(ies) removed)	**SDPOO**
☐	☐	Ovarian cystectomy (cyst on ovary removed)	**SDPOC**
☐	☐	Appendectomy (removal of appendix)	**SDPA**
☐	☐	Cholecystectomy (removal of gallbladder)	**SDPCH**
☐	☐	Tubal ligation (tubes tied)	**SDPTL**
☐	☐	Other surgery (Specify: _____)	**SDPOT** **SDPOTS**

14. Were you admitted to the Intensive Care Unit (ICU) during or immediately after your pregnancy?
- ☐ -3. Not Sure **ICUADM**
- ☐ 0. No
- ☐ 1. Yes → Please specify why: **ICUADMS1** _____

ICUADMS2 _____

Directions:
- If this pregnancy did not end in a still birth or live birth, please skip to the **last page** of this survey. Thank you.
- If you had a still birth or live birth please continue to the **next page**.

15. Did you go into preterm labor (contractions which started before 37 weeks of pregnancy with dilation of your cervix) during this pregnancy?

☐ -3. Not Sure → *skip to Q16* **PTLABOR**

☐ 0. No → *skip to Q16*

☐ 1. Yes →

15.1 Were you hospitalized for pre-term labor? ☐ 0. No ☐ 1. Yes **PTLABORH**

15.2 How many weeks pregnant were you? _____ (weeks) **PTLABORW**

16. Did your water break prior to 37 weeks?

☐ -3. Not Sure → *skip to Q17* **WBP37W**

☐ 0. No → *skip to Q17*

☐ 1. Yes→ 16.1 How many weeks pregnant were you when your water broke? _____ (weeks) **WBP37WW**

17. Did you have a vaginal delivery?

☐ 0. No → *skip to Q18* **VAGDEL**

☐ 1. Yes →

17.1 Please check "No" or "Yes" to each to specify if you have had any of the following complications after delivery:

No	Yes		
☐	☐	a. Infection of a vaginal tear	**VAGDELI**
☐	☐	b. Unintentional loss of urine	**VAGDELU**
☐	☐	c. Unintentional loss of stool	**VAGDELS**
☐	☐	d. Other, (Specify: _____	**VAGDELO** **VAGDELOS** _____)

18. Did you have a cesarean section (c-section)?

☐ 0. No → *skip to Q19* **CESAR**

☐ 1. Yes →

18.1 What was the main reason?: **CESARR**

- ☐ -3. Not sure
- ☐ 1. Prior c-section
- ☐ 2. Baby was breech (head was up)
- ☐ 3. Multiples birth (2 or more babies)
- ☐ 4. Labor not progressing
- ☐ 5. Baby not tolerating labor (distress)
- ☐ 6. Other (Specify _____ **CESAROS** _____)

18.2 Did you have a wound complication after your c-section? (e.g., an infection, needed to have incision opened) **CESARWC**

- ☐ -3. Not sure
- ☐ 0. No
- ☐ 1. Yes

Directions:

- If this pregnancy did not end in a live birth, please skip to the **last page** of this survey. Thank you.
- If you had a live birth please continue to the **next page**.

19. Please complete the questions below regarding your **live born infant(s) from this pregnancy only**.

	Birth Weight	Length	Birth defect? No (0) Yes (1)	Birth injury? No (0) Yes (1)	NICU admission? No (0) Yes (1)
Baby 1	LBI1LBS lbs LBI1OZ oz	LBI1IN inches	LBI1BD	LBI1BI	LBI1NICU
Baby 2	LBI2LBS lbs LBI2OZ oz	LBI2IN inches	LBI2BD	LBI2BI	LBI2NICU
Baby 3	LBI3LBS lbs LBI3OZ oz	LBI3IN inches	LBI3BD	LBI3BI	LBI3NICU
Baby 4	LBI4LBS lbs LBI4OZ oz	LBI4IN inches	LBI4BD	LBI4BI	LBI4NICU
Baby 5	LBI5LBS lbs LBI5OZ oz	LBI5IN inches	LBI5BD	LBI5BI	LBI5NICU

☐ *Check here if more than 5 babies.* MT5B

20. If your child had a birth defect, birth injury (e.g. fracture, dislocation, nerve damage), or Neonatal Intensive Care Unit (NICU) admission, please provide additional information below:

Type of birth defect: _____ TBD1

_____ TBD2

Type of birth injury: _____ TBI1

_____ TBI2

Reason for NICU admission: _____ RNICU1

_____ RNICU2

21. Following delivery, did you breast feed?

☐ 0. No → *skip to next page*

☐ 1. Yes → BFEED

21.1 How long did you breast feed? BFEEDL

- ☐ 1. Currently breastfeeding
- ☐ 2. Less than 6 weeks
- ☐ 3. 6 weeks to less than 3 months
- ☐ 4. 3 months to less than 6 months
- ☐ 5. 6 months or longer

Please continue to next page.

Directions:

- Please list the names and locations of where you received care for this pregnancy.
- Please complete as much information as you can. Write NONE for any locations that are not applicable.
- Please tell the Research Coordinator if you had any medical procedures performed at an **out-patient surgical facility/hospital/birthing center** during your pregnancy for any reason, including delivery.

Fertility treatment:

Approximate date of care: ___/___/_____- ___/___/_____

Name of Health Care Provider(s):_____

Name of Medical Practice:_____

Address:_____

City_____ State _____ Zip code _____

Prenatal Care:

Approximate date of care: ___/___/_____ - ___/___/_____

Name of Health Care Provider(s):_____

Name of Medical Practice:_____

Address:_____

City_____ State _____ Zip code _____

Medical clinic, hospital or birthing center for end of pregnancy (e.g., delivery, miscarriage, abortion):

Approximate date of care: ___/___/_____

Name of Health Care Provider(s):_____

Name of Medical Practice:_____

Address:_____

City_____ State _____ Zip code _____

Hospitalization during pregnancy (not necessarily related to pregnancy):

Approximate date of care: ___/___/_____

Name of Health Care Provider(s):_____

Name of Medical Practice:_____

Address:_____

City_____ State _____ Zip code _____

Additional location (specify reason for care): _____

Approximate date of care: ___/___/_____

Name of Health Care Provider(s):_____

Name of Medical Practice:_____

Address:_____

City_____ State _____ Zip code _____

Please ask the LABS coordinator for an additional form if you have more locations to record.