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[RELEASEID]

Release Participant ID

Complete this form for all randomized participants at the 1 year postpartum visit (48 weeks – 56 weeks). Record medical conditions since the LM02A was completed. Please indicate whether the participant has been diagnosed with any of the following medical conditions during the pregnancy and if they are taking any medications for the condition.

Days between delivery to date form completed: **[LM08ADAYS]**

days

	a. Condition Present?	If Yes, b. Medication use?
1. High blood pressure (hypertension), NOT including gestational hypertension or preeclampsia	<input type="checkbox"/> ₁ Yes, diagnosed <u>during</u> the study pregnancy <input type="checkbox"/> ₂ Yes, diagnosed <u>after</u> the study pregnancy <input type="checkbox"/> ₀ No <p style="text-align: right;">[LBP]</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LBPMED]</p>
2. Hypothyroidism (underactive thyroid)	<input type="checkbox"/> ₁ Yes, diagnosed <u>during</u> the study pregnancy <input type="checkbox"/> ₂ Yes, diagnosed <u>after</u> the study pregnancy <input type="checkbox"/> ₀ No <p style="text-align: right;">[LUTHY]</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LUTHYMED]</p>
3. Depression	<input type="checkbox"/> ₁ Yes, diagnosed <u>during</u> the study pregnancy <input type="checkbox"/> ₂ Yes, diagnosed <u>after</u> the study pregnancy <input type="checkbox"/> ₀ No <p style="text-align: right;">[LDEP]</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LDEPMED]</p>
4. Anxiety disorder	<input type="checkbox"/> ₁ Yes, diagnosed <u>during</u> the study pregnancy <input type="checkbox"/> ₂ Yes, diagnosed <u>after</u> the study pregnancy <input type="checkbox"/> ₀ No <p style="text-align: right;">[LANX]</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LANXMED]</p>
5. Polycystic ovary syndrome (PCOS)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LPCOS]</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LPCOSMED]</p>
6. Asthma	<input type="checkbox"/> ₁ Yes, diagnosed <u>during</u> the study pregnancy <input type="checkbox"/> ₂ Yes, diagnosed <u>after</u> the study pregnancy <input type="checkbox"/> ₀ No <p style="text-align: right;">[LASTH]</p>	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <p style="text-align: right;">[LASTHMED]</p>

LIFE-Moms LM08A: Postpartum Medical History Form

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7. Diabetes	<input type="checkbox"/> ₁ Yes, diagnosed <u>after</u> the study pregnancy <input type="checkbox"/> ₀ No [LDIAB]	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No [LDIABMED]
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