ChiLDReNLink: PROBE

Form 04 Pregnancy History PROBE

A: VISIT

This form is to be completed only with information from the biological mother of the participant. Biological mother refers to the woman who was pregnant with the participant.

A1	Please indicate the primary source(s) of information for the completion of this form (check all that apply):	□ Biological Mother □ Biological Father □ Guardian(s) □ Mother, not biological □ Father, not biological □ Medical Record □ Other (specify): _____
A2	Is prenatal data of the infant's biological mother available?	O No O Yes → **go to B1**
A3	Reason for lack of data:	□ Adoption □ Foster child □ Death □ Other (specify): _____

B: PRENATAL HISTORY OF BIOLOGICAL MOTHER

B1	Did you have at least one prenatal care visit prior to the birth of your child?	O No O Yes
B2	Was this a multiple birth pregnancy? If Yes, how many babies did you deliver?	O No O Yes (specify): _____
B4	Were you being treated for infertility at the time that you became pregnant?	O No → **go to B6** O Yes
B5	If Yes, please specify:	_____
B6	Did you have gestational diabetes? (Alternate wording: Were you told that you had high blood sugar during your pregnancy?)	O No → **go to 8** O Yes
B7	How was your diabetes (high blood sugar) controlled? (check all that apply)	□ Diet □ Insulin □ Oral agents □ Did nothing to control it
B8	Were you on bedrest during your pregnancy?	O No → **go to C1** O Yes
B9	If Yes, onset:	___ ___ O weeks of pregnancy O Don't Know
B10	Specify reason for bedrest:	_____

C: ILLNESSES DURING PREGNANCY

C1	Do you have any chronic illnesses, such as diabetes or asthma? If yes, please complete the table below for each illness.	O No	O Yes	O Don't Know
C4	Did you have any (other) illnesses during this pregnancy? If yes, please complete the table below for each illness.	O No	O Yes	O Don't Know

C: ILLNESSES DURING PREGNANCY

C10	Illnesses During Pregnancy

10. Self-Reported Diagnosis	11. Types of Visit (check all that apply)		12. Trimester (check all that apply)
	□ Did not see health professional □ Nurse practitioner □ Physician visit □ Inpatient hospitalization	□ Nurse visit □ Physician assistant □ Emergency room visit □ Other, specify: ____________	□ 1 □ 2 □ 3 □ Continuing
	□ Did not see health professional □ Nurse practitioner □ Physician visit □ Inpatient hospitalization	□ Nurse visit □ Physician assistant □ Emergency room visit □ Other, specify: ____________	□ 1 □ 2 □ 3 □ Continuing
	□ Did not see health professional □ Nurse practitioner □ Physician visit □ Inpatient hospitalization	□ Nurse visit □ Physician assistant □ Emergency room visit □ Other, specify: ____________	□ 1 □ 2 □ 3 □ Continuing
	□ Did not see health professional □ Nurse practitioner □ Physician visit □ Inpatient hospitalization	□ Nurse visit □ Physician assistant □ Emergency room visit □ Other, specify: ____________	□ 1 □ 2 □ 3 □ Continuing
	□ Did not see health professional □ Nurse practitioner □ Physician visit □ Inpatient hospitalization	□ Nurse visit □ Physician assistant □ Emergency room visit □ Other, specify: ____________	□ 1 □ 2 □ 3 □ Continuing

D: PREGNANCY HISTORY

D1	What was the estimated gestational age of your baby at delivery?	___ ___ O weeks O Don't Know
D2	What was your infant's birth weight?	___ ___ O kgs O lbs O oz ___ ___ O oz O Don't Know O Not Done
D3	What was your infant's length at birth?	___ ___ O cm O feet O inches ___ ___ O inches O Don't Know O Not Done
D4	What was your baby's age at discharge from the hospital?	___ ___ O weeks O days O Don't Know O Not Applicable

E: PAST PREGNANCY HISTORY OF BIOLOGICAL MOTHER

E1	How many times have you been pregnant?	O 1 O 2 O 3 O 4 O 5 O 6 or more

Please describe each pregnancy, beginning with your first. If you or your husband were treated for infertility at any time, please tell us.

Coordinator: Do not include information on the most recent pregnancy, resulting in the birth of the patient. For live births, please use one line per infant. If there was a treatment for infertility, please indicate type of treatment in the comment box.

E2	Past Pregnancy History

E: PAST PREGNANCY HISTORY OF BIOLOGICAL MOTHER

3. Year of birth/loss:	4. Outcome (check all that apply):	CG5. Number of fetuses:	6. Sex:	7. Complications (check all that apply):	8. Current Status:	9. Comments:
__ __ __ __	O Live birth O Multiple birth O Miscarriage / spontaneous abortion O Therapeutic abortion O Stillbirth	__ __	O Male O Female O Unknown	□ Gestational diabetes □ Hypertension □ Pre-eclampsia □ Eclampsia □ High blood pressure /hypertension □ Bed rest □ Vaginal infection (specify in comments box) □ Spotting/bleeding □ Liver problems (cholestasis/HELLP) (specify in comments box) □ Other, specify in comments box □ None	O Alive and well O Requires regular medical care O Deceased (specify cause of death in comments box) O Other (specify in comments box)	
__ __ __ __	O Live birth O Multiple birth O Miscarriage / spontaneous abortion O Therapeutic abortion O Stillbirth	__ __	O Male O Female O Unknown	□ Gestational diabetes □ Hypertension □ Pre-eclampsia □ Eclampsia □ High blood pressure /hypertension □ Bed rest □ Vaginal infection (specify in comments box) □ Spotting/bleeding □ Liver problems (cholestasis/HELLP) (specify in comments box) □ Other, specify in comments box □ None	O Alive and well O Requires regular medical care O Deceased (specify cause of death in comments box) O Other (specify in comments box)	
__ __ __ __	O Live birth O Multiple birth O Miscarriage / spontaneous abortion O Therapeutic abortion O Stillbirth	__ __	O Male O Female O Unknown	□ Gestational diabetes □ Hypertension □ Pre-eclampsia □ Eclampsia □ High blood pressure /hypertension □ Bed rest □ Vaginal infection (specify in comments box) □ Spotting/bleeding □ Liver problems (cholestasis/HELLP) (specify in comments box) □ Other, specify in comments box □ None	O Alive and well O Requires regular medical care O Deceased (specify cause of death in comments box) O Other (specify in comments box)	
__ __ __ __	O Live birth O Multiple birth O Miscarriage / spontaneous abortion O Therapeutic abortion O Stillbirth	__ __	O Male O Female O Unknown	□ Gestational diabetes □ Hypertension □ Pre-eclampsia □ Eclampsia □ High blood pressure /hypertension □ Bed rest □ Vaginal infection (specify in comments box) □ Spotting/bleeding □ Liver problems (cholestasis/HELLP) (specify in comments box) □ Other, specify in comments box □ None	O Alive and well O Requires regular medical care O Deceased (specify cause of death in comments box) O Other (specify in comments box)	
__ __ __ __	O Live birth O Multiple birth O Miscarriage / spontaneous abortion O Therapeutic abortion O Stillbirth	__ __	O Male O Female O Unknown	□ Gestational diabetes □ Hypertension □ Pre-eclampsia □ Eclampsia □ High blood pressure /hypertension □ Bed rest □ Vaginal infection (specify in comments box) □ Spotting/bleeding □ Liver problems (cholestasis/HELLP) (specify in comments box) □ Other, specify in comments box □ None	O Alive and well O Requires regular medical care O Deceased (specify cause of death in comments box) O Other (specify in comments box)	

F: PRENATAL TESTS FROM MOTHER AND MEDICAL RECORD		
F1	Did the mother have any abnormal prenatal ultrasounds?	O No → **go to G1** O Yes
D23	Please specify which abnormalities were noted and the weeks of gestation they were first observed (check all that apply):	□ Cardiac anomaly, specify week: ___ ___ □ Central nervous system anomaly, specify week: ___ ___ □ Renal anomaly, specify week: ___ ___ □ Cystic abnormality of the liver, specify week: ___ ___ □ Oligohydraminos (too little amniotic fluid), specify week: ___ ___ □ Polyhydramnios (too much amniotic fluid), specify week: ___ ___ □ Other, specify type and week: _____ ___ ___

G: MEDICINAL AND OTHER SUBSTANCE ABUSE				
G1	Did you take any prescription drugs during your pregnancy?	O No	O Yes	O Refused
G2	Did you take any over-the-counter medications, vitamins, or supplements during your pregnancy?	O No	O Yes	O Refused
G3	Did you take any herbal supplements or remedies during your pregnancy?	O No	O Yes	O Refused
G4	Did you use any recreational drugs (such as marijuana or cocaine) during your pregnancy?	O No	O Yes	O Refused
G5	If Yes is answered to any of the above questions (G-1 thru G-4), please complete the table below for each medication, supplement, or drug:			

5. Name of medication/vitamin/supplement/drug:	**6. Discontinued due to side-effects?**		**7. Trimester(s) medication was taken:**
_____	O No	O Yes	□ First trimester □ Second trimester □ Third trimester
_____	O No	O Yes	□ First trimester □ Second trimester □ Third trimester
_____	O No	O Yes	□ First trimester □ Second trimester □ Third trimester
_____	O No	O Yes	□ First trimester □ Second trimester □ Third trimester
_____	O No	O Yes	□ First trimester □ Second trimester □ Third trimester

H: ALCOHOL AND TOBACCO USE		
H1	Did you drink alcohol during your pregnancy?	O No → **go to H5** O Yes O NA (if not biological mother) → **go to H5** O Refused → **go to H5**
H2	Did you stop drinking at some time during your pregnancy?	O No O Yes

H: ALCOHOL AND TOBACCO USE		
H3	In which trimester(s) did you drink? (check all that apply)	□ First trimester □ Second trimester □ Third trimester
H4	When you drank during your pregnancy, how much did you drink on average?	O Less than a drink per week O 1 to 5 drinks per week O About 1 drink each day O Between 1-2 drinks each day O More than 2 drinks each day O Refused
H5	During your pregnancy, did you smoke cigarettes?	O No → **go to H8** O Yes O NA (if not biological mother) → **go to H8** O Refused → **go to H8**
H6	In which trimester(s) did you smoke?	□ First trimester □ Second trimester □ Third trimester
H7	On average, how many cigarettes did you smoke per day during your pregnancy?	___ ___ Cigarettes per day (1 pack = 20 cigarettes)
H8	During your pregnancy, did you use any other tobacco products such as cigars, pipes, chewing tobacco, or snuff?	O No → **go to H10** O Yes O Refused → **go to H10**
H9	Which types of tobacco products did you use? (check all that apply)	□ Cigars □ Pipes □ Chewing tobacco □ Snuff □ Other (specify):_____
H10	During your pregnancy, were you regularly exposed to cigarette, cigar, or pipe smoke from other people?	O No → **Done** O Yes O Refused → **Done**
H11	On average, how many hours a day were you exposed to tobacco smoke from other people?	___ ___ hours per day