A1. Site/Study ID #:___ ___ / ___ ___ ___ ___ A2. Date of Interview:___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) A3. Staff Initials:___ ___ ___

To DCC ☐

Biological mother in this form ONLY refers to the woman who was pregnant with the infant.

A4. *Please indicate the primary source(s) of information for the completion of this form (check all that apply):*

a. ☐ Biological Mother → **Go to B1**
b. ☐ Biological Father
c. ☐ Guardian(s)
d. ☐ Mother, not biological
e. ☐ Father, not biological
f. ☐ Medical Record
g. ☐ Other (Specify:_____)

A5. *Is prenatal data of the infant's biological mother available?* 1. ☐ No 2. ☐ Yes → **Go to B1**

a. Reason for lack of data:

1. ☐ Adoption 2. ☐ Foster child 3. ☐ Death 4. ☐ Other (Specify:_____)

---------- DO NOT CONTINUE IF THERE IS NO INFORMATION ON THE BIOLOGICAL MOTHER ----------

SECTION B: PRENATAL HISTORY OF BIOLOGICAL MOTHER

B1. Did you have at least one prenatal care visit prior to the birth of your child? 1. ☐ No 2. ☐ Yes

B2. Was this a multiple birth pregnancy? 1. ☐ No → **Go to B3** 2. ☐ Yes

a. How many babies did you deliver? ___

B3. Were you being treated for infertility at the time that you became pregnant? 1. ☐ No
2. ☐ Yes → (Specify:_____)

B4. Did you have gestational diabetes? 1. ☐ No → **Go to B6** 2. ☐ Yes

[*Alternate wording:* Were you told that you had high blood sugar during your pregnancy?]

b. How was your diabetes [high blood sugar] controlled *(check all that apply)*?

bi. ☐ Diet
bii. ☐ Insulin
biii. ☐ Oral agents
biv. ☐ Did nothing to control it

B6. Were you on bedrest during your pregnancy? 1. ☐ No → **Go to B7** 2. ☐ Yes

a. Onset: _____ _____ Weeks of pregnancy 1. ☐ DK

b. Specify reason:_____

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

ILLNESSES DURING PREGNANCY

B7. Do you have any chronic illnesses, such as diabetes or asthma? *[If yes]* Did you see a doctor for it during your pregnancy?

1. ☐ No 2. ☐ Yes → **Complete table B9** 3. ☐ DK

B8. Did you have any (other) illnesses during this pregnancy? *[If yes]* When did it occur and did you see a doctor or any medical person for it?

1. ☐ No 2. ☐ Yes → **Complete table B9** 3. ☐ DK

B9.

Seq. No.	Self-Reported Diagnosis	Types of Visit	Trimester (Check all that apply)
01		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
02		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
03		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
04		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
05		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
06		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
07		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing
08		___ ___ , ___ ___, ___ ___	☐ 1 ☐ 2 ☐ 3 ☐ Continuing

If more than 8 lines, continue on additional form(s) and sequentially number the pages. If more than one page: Page _____ of _____.

B10. Total number of lines: ___ ___

Types of Visits:

A0. Did not see health professional
A1. Nurse visit
A2. Nurse practitioner
A3. Physician assistant
A4. Physician visit
A5. Emergency room visit
A6. Inpatient hospitalization
A7. Other (Specify:_____)
A8. Other (Specify:_____)
A9. Other (Specify:_____)
A10. Other (Specify:_____)

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

SECTION C: LABOR AND DELIVERY FOR PREGNANCY RELATED TO THIS INFANT

C4. What was the estimated gestational age of *your baby* at delivery? ___ ___ Weeks 1. ☐ DK

C5. What was *your infant*'s birth weight? ___ ___ lbs ___ ___ oz OR ___ . ___ ___ ___ kg 1. ☐ DK

C6. What was *your infant's* length at birth? ___ ___ inches OR ___ ___ cm 1. ☐ DK

C9. What was *your baby's* age at discharge from the hospital? ___ ___ weeks OR ___ ___ ___ days 1. ☐ DK 8. ☐ Not Applicable

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

SECTION D: PAST PREGNANCY HISTORY OF BIOLOGICAL MOTHER

D1. How many times have you been pregnant?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

D2. 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.*

				Complete for Live Births Only			
	Year of Birth/Loss	**Outcome** (choose all that apply from list below)	**# Fetuses**	**Sex M/F/U**	**Complications** (choose all that apply from list below)	**Current Status** (choose one from list below)	**Comments**
01		_____, _____, _____			_____, _____, _____		
02		_____, _____, _____			_____, _____, _____		
03		_____, _____, _____			_____, _____, _____		
04		_____, _____, _____			_____, _____, _____		
05		_____, _____, _____			_____, _____, _____		
06		_____, _____, _____			_____, _____, _____		
07		_____, _____, _____			_____, _____, _____		
08		_____, _____, _____			_____, _____, _____		

If more than 8 lines, continue on additional form(s) and sequentially number the pages. If more than one page: Page _____ of _____.

D3. *How many lines are used?* ___ ___

Outcomes:
A1. Live birth
A2. Multiple birth
A3. Miscarriage/spontaneous abortion
A4. Therapeutic abortion
A5. Stillbirth

Complications:
B1. Gestational diabetes
B2. Hypertension
B3. Pre-eclampsia
B4. Eclampsia
B5. High blood pressure/hypertension
B6. Bed rest
B7. Vaginal infection (Specify in comments box)
B8. Spotting/bleeding
B9. Liver problems (cholestasis/HELLP) (specify in comments box)
B10. Other (specify in comments box)
B12. Other (specify in comments box)
B13. Other (specify in comments box)
B11. None

Current Status:
C1. Alive and well
C2. Requires regular medical care
C3. Deceased (specify cause of death in comments box)
C4. Other (Specify:_____)
C5. Other (Specify:_____)
C6. Other (Specify:_____)
C7. Other (Specify:_____)

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

SECTION F: PRENATAL TESTS FROM MOTHER AND MEDICAL RECORD

F3. Ultrasound: 1. ☐ No → **Go to G1** 2. ☐ Yes

c. Please specify which abnormalities were noted *(check all that apply)*: 1. ☐ DK

		Week of gestation when first observed
ci.	☐ Cardiac anomaly	___ ___ wks
cii.	☐ Central nervous system anomaly	___ ___ wks
ciii.	☐ Renal anomaly	___ ___ wks
civ.	☐ Cystic abnormality of the liver	___ ___ wks
cv.	☐ Oligohydraminos [too little amniotic fluid]	___ ___ wks
cvi.	☐ Polyhydraminos [too much amniotic fluid]	___ ___ wks
cvii.	☐ Other (Specify:_____)	___ ___ wks

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

SECTION G: MEDICINAL AND OTHER SUBSTANCE USE

G1. Did you take any prescription drugs during your pregnancy? 1. ☐ No 2. ☐ Yes 9. ☐ Refused

G2. Did you take any over-the-counter medications, vitamins or supplements during your pregnancy? 1. ☐ No 2. ☐ Yes 9. ☐ Refused

G3. Did you take any herbal supplements or remedies during your pregnancy? 1. ☐ No 2. ☐ Yes 9. ☐ Refused

G4. Did you use any recreational drugs (such as marijuana or cocaine) during your pregnancy? 1. ☐ No 2. ☐ Yes 9. ☐ Refused

IF "YES" IS ANSWERED TO ANY OF THE ABOVE QUESTIONS (G1-G4), PLEASE COMPLETE TABLE G5 BELOW.

G5.

Seq. No.	Answer to G1/2/3/4	Name of Medication/Vitamin/Supplement./Drug (print name precisely)	Check if discontinued due to side effects	Trimester Medication Was Taken (check all that apply)		
01			☐	☐ 1	☐ 2	☐ 3
02			☐	☐ 1	☐ 2	☐ 3
03			☐	☐ 1	☐ 2	☐ 3
04			☐	☐ 1	☐ 2	☐ 3
05			☐	☐ 1	☐ 2	☐ 3
06			☐	☐ 1	☐ 2	☐ 3
07			☐	☐ 1	☐ 2	☐ 3
08			☐	☐ 1	☐ 2	☐ 3
09			☐	☐ 1	☐ 2	☐ 3
10			☐	☐ 1	☐ 2	☐ 3

If more than 10, continue on additional forms and sequentially number the pages. If more than one page: Page _____ of _____.

G6. *Total number of items listed:* ___ ___

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

SECTION H: ALCOHOL AND TOBACCO USE

We are now going to ask you questions about drinking alcohol. Included are liquor (such as whiskey or gin), beer, wine, wine coolers, and any other type of alcoholic beverage.

H6. Did you drink alcohol during your pregnancy?

1. ☐ No → **Go to H14**
2. ☐ Yes
8. ☐ NA (if not biological mother) → **Go to H14**
9. ☐ Refused → **Go to H14**

H7. Did you stop drinking at some time during your pregnancy?

1. ☐ No
2. ☐ Yes

H8. In which trimester(s) did you drink (check all that apply)?

a. ☐ First trimester
b. ☐ Second trimester
c. ☐ Third trimester

H9. When you drank during your pregnancy, how much did you drink on average?

1. ☐ Less than a drink per week
2. ☐ 1 to 5 drinks per week
3. ☐ About 1 drink each day
4. ☐ Between 1-2 drinks each day
5. ☐ More than 2 drinks each day
9. ☐ Refused

We are now going to ask you questions about cigarette smoking.

H14. During your pregnancy, did you smoke cigarettes?

1. ☐ No → **Go to H17**
2. ☐ Yes
8. ☐ NA (if not biological mother) → **Go to END**
9. ☐ Refused → **Go to H17**

H15. In which trimester(s) did you smoke (check all that apply)?

a. ☐ First trimester
b. ☐ Second trimester
c. ☐ Third trimester

H16. On average, how many cigarettes did you smoke per day during your pregnancy? ___ ___ Cigarettes per day (1 pack = 20 cigarettes)

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___

H17. During your pregnancy did you use any other tobacco products such as cigars, pipes, chewing tobacco or snuff?

1. ☐ No → **Go to H18** 2. ☐ Yes 9. ☐ Refused → **Go to H18**

a. Which type(s) of tobacco products did you use? (check all that apply)

ai. ☐ Cigars

aii. ☐ Pipes

aiii. ☐ Chewing tobacco

aiv. ☐ Snuff

av. ☐ Other (Specify:_____)

H18. During your pregnancy were you regularly exposed to cigarette, cigar or pipe smoke from other people?

1. ☐ No → **END** 2. ☐ Yes 9. ☐ Refused → **END**

a. On average, how many hours a day were you exposed to tobacco smoke from other people? ___ ___ hours per day