Site Number: __ __ __ __ Screening ID: __ __ __ __ __ - __ Participant Letters: __ __ __

Study Coordinator completes this form after the Pregnant Woman is randomized.

A. VISIT INFORMATION

1. Date of visit (*e.g. 05/Sep/2006*): __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
2. Week of pregnancy: __ __ weeks
3. Date of randomization: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)
4. Randomization color (*check one*): ☐ 1 Gray ☐ 2 Yellow ☐ 3 Red ☐ 4 Orange

B. MEDICAL HISTORY

1. What was her weight prior to this pregnancy? __ __ __ lb or __ __ __ . __ kg
2. Expected date of delivery: __ __ / __ __ __ / __ __ __ _ (DAY / MONTH / YEAR)
3. Has a physician ever told her that she has any of the following conditions?

Condition/Disease:	Ever had?	1) If YES, within last year?
Cardiovascular		
a. High blood pressure	Y N	Y N
b. High cholesterol	Y N	Y N
c. Congenital heart disease or heart problems	Y N	Y N
Respiratory		
d. Asthma	Y N	Y N
Gastrointestinal		
e. Ulcer (stomach or duodenal)	Y N	Y N
f. Gallstones, disease or surgery of the gallbladder	Y N	Y N
g. Hepatitis/Liver disease	Y N	Y N
h. Colitis or colon problems	Y N	Y N
Neurologic		
i. Epilepsy, convulsions or seizures	Y N	Y N

Site: __ __ __ __ Screening ID: __ __ __ __ __ __ - __ Letters: __ __ __ Visit Date: __ __/__ __/__ __ __ __

B. MEDICAL HISTORY (CONTINUED)

Condition/Disease:	Ever had?	1) If YES, within last year?
Endocrine		
j. Thyroid disease	Y N	Y N
Infections		
k. Infectious mononucleosis	Y N	Y N
l. Frequent urinary tract infections	Y N	Y N
Rheumatologic/Autoimmune		
m. Pernicious anemia	Y N	Y N
n. Alopecia	Y N	Y N
o. Psoriasis	Y N	Y N
p. Celiac Sprue	Y N	Y N
q. Gout	Y N	Y N
r. Rheumatologic disease	Y N	Y N
2) If YES, specify:		
Hematologic/Oncologic		
s. Cancer	Y N	Y N
2) If YES, specify:		
Other		
t. Medication allergies	Y N	Y N
u. Seasonal allergies	Y N	Y N
v. Other:	Y N	Y N
2) If OTHER, describe:		

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*

Site: __ __ __ __ Screening ID: __ __ __ __ __ __ - __ Letters: __ __ __ Visit Date: __ __/__ __/__ __ __ __

C. BLOOD SAMPLES COLLECTED

	Collected?	a. Comments:
1. Fatty Acids (RBC) and Inflammatory Mediators	Y N	
2. Biochemical Autoantibodies	Y N	
3. Vitamin D levels and C-Reactive Protein (CRP)	Y N	

Initials (first, middle, last) of person completing this form: __ __ __ (F M L)

Date form completed: __ __ / __ __ __ / __ __ __ __ (DAY / MONTH / YEAR)

On all questions write "?" if the desired information is currently unavailable, but is being checked and will be known in future updates. Write "" if the desired information is permanently unavailable (i.e. will not be known in any future updates).*