Participant ID:	Date of Registration:	
Local ID:	Letters:	
Status:		
Site:		

Pregnancy Confirmation

* These fields are red	quired in order to SAVE the form				
* These fields are required	in order to COMPLETE the form				
Date of Visit: * Date					
Interviewer User ID: *					
A. Pregnancy Information					
1. Date of positive pregnancy test:	'				
2. Date of last menstrual cycle:					
3. Estimated date of delivery:					
4. Is the participant planning on carrying the pregnancy to term?	○ Yes ○ No ○ Unknown				
5. Is the participant willing to continue with future follow-up visits?	○ Yes ○ No ○ Unknown				
6. Has the participant's obstetric care provider been informed of her participation in this study?	○ Yes ○ No ○ Unknown				
B. Pregnancy History					
Indicate the total number of prior pregnancies (not including this one):	Unknown				
2. Has the participant ever experienced a complication of pregnancy?	○ Yes ○ No ○ Unknown				
If YES, a. Has the participant ever experienced a miscarriage?	○ Yes ○ No ○ Unknown				
b. Has the participant ever experienced a pregnancy that resulted in a still birth?	Yes No Unknown				
c. Has the participant ever experienced a pregnancy that resulted in neonata death?	Yes No Unknown				
d. Has the participant ever experienced a pre-term delivery ($<$ 37 gestationa weeks)?	I				
e. Has the participant ever experienced a post-term delivery (>42 gestational weeks)?	Yes No Unknown				