Health History and COVID-19 Questions

1. What is your height:
   _____feet
   _____inches

2. What is your pre-pregnancy weight: _____ pounds (lbs)

3. In a typical week, do you do any vigorous-intensity or moderate-intensity sports, fitness or recreational activities that cause increases in breathing or heart rate like walking, bicycling or swimming for at least 10 minutes continuously?
   O Yes
   O No

4. Did you receive a flu vaccination in the last year?
   O Yes
   O No

5. Has a doctor or other health care provider told you that you have any of the following conditions: (CHECK ALL THAT APPLY)

   O High blood pressure prior to pregnancy → go to 5a
   O Diabetes prior to pregnancy → go to 5b.
   O Asthma
   O Other lung conditions → go to 5c
   O Heart problems → go to 5d
   O Thyroid problems
   O Blood clot in your legs, lungs, or other area of your body that required you to be on blood thinners
   O Depression
   O Anxiety
   O HIV or AIDS
   O Any condition that decreases your ability to fight infection (immunosuppression). →go to 5e.
   O Other major medical condition → go to 5f
   O None of the above

   5a. Do you take medications for high blood pressure?
      O Yes
      O No

   5b. Do you take medications for your diabetes?
      O Yes
      O No

   5c. Please describe your lung condition: _____

5d. Please describe your heart problems: _____
5e. Please describe your condition that decreases your ability to fight infection (immunosuppression):
5f. Other major medical condition, please describe: _____

6. Are you taking any medications that decrease your ability to fight infection (immunosuppressant)?
   O Yes, please specify
   O No

6a. If yes, please specify the medications: _____

7. Are you taking any other medications regularly besides vitamins or iron?
   o Yes (please list below)
   o No
   Please list medications: _____

Coronavirus/COVID-19 Questions

8. What symptoms did you have that led you to be tested or suspected of Coronavirus/COVID-19? (Check all that apply)
   O Fever
   O Cough → go to 9a/9b
   O Shortness of breath
   O Dizziness or fainting
   O Body aches
   O Runny nose
   O Sore throat
   O Loss of sense of smell or taste
   O Sneezing
   O Fatigue
   O Nausea
   O Vomiting
   O Diarrhea
   O Headache
   O Other symptoms → go to 8c
   O None → Go to 11

   8a. Dry cough?
   O Yes
   O No

   8b. “Wet” cough (one that makes a lot of mucus or sputum)?
   O Yes

O No

8c. If other symptoms, please specify: _____

9. Which of these symptoms was the first thing you noticed? (mark only one)
   O Fever
   O Cough → go to 9a/9b
   O Shortness of breath
   O Dizziness or fainting
   O Body aches
   O Runny nose
   O Sore throat
   O Loss of sense of smell or taste
   O Sneezing
   O Fatigue
   O Nausea
   O Vomiting
   O Diarrhea
   O Headache
   O Other symptoms→ go to 9c
   O None

   9a. Dry cough?
   O Yes
   O No

   9b. "Wet" cough (one that makes a lot of mucus or sputum)?
   O Yes
   O No

   9c. If other symptoms, please specify: _____

10. When did your symptoms start? (If you don't know the exact date, make your best guess) _____DATE

11. Have you traveled outside of your city or town in the last month?
   O Yes
   O No

   11a. If yes, Where did you travel: _____

12. Has anyone you have close contact with tested positive for Coronavirus?
   O Yes
   O No

13. Has anyone you have close contact with had a fever, cough, or flu-like symptoms in the last month?
    - O Yes
    - O No

14. What is your current status with Coronavirus/COVID-19?
    - O Diagnosed with Coronavirus (tested positive for Coronavirus) → go to 14a.
    - O Tested negative for Coronavirus → go to 14b.
    - O Waiting for my test results
    - O I have not been tested
    - O Other → go to 14c.

    14a. What date were you told you had COVID-19? _____

    14b. What date were you told you were negative for COVID-19? _____

    14c. If other, please specify: _____

15. Have you been tested for the flu virus?
    - O Yes → go to 15a
    - O No

15a. Have you been diagnosed with the flu?
    - O Yes
    - O No

16. Are you currently in the hospital?
    - O Yes → go to 16a
    - O No → go to 16b

16a. Are you in the Intensive Care Unit (ICU)?
    - O Yes
    - O No

16b. Are you quarantined (including self-quarantined)?
    - O Yes, I am quarantined alone
    - O Yes, I am quarantined with others
    - O No, I am not quarantined

Reproductive Health History

If you do not know the exact answer to any question, please make your best guess.

1. Are you currently pregnant?
   - O Yes → go to 1a.
   - O No → go to 2.

1a. Do you know how far along you are in pregnancy?
   - O Yes → go to 1b.
   - O No → go to 1c

1b. How many weeks are you into pregnancy? That is, how many weeks has it been since the first day of your last menstrual period? If you don't know, please make your best guess
___ weeks

1c. During your pregnancy, did you ever consider having an abortion?
   - O Yes → continue
   - O No → Skip to 1e
   - O Decline to State → Skip to 1e

1d. Are you still considering having an abortion?
   - O Yes → Skip to 2
   - O No → continue
   - O Decline to State → continue

1e. Do you know your due date?
   - O Yes → go to 1f.
   - O No → go to 1g.

1f. What is your due date? _____

1g. Are you pregnant with one fetus or infant or multiples?
   - O One fetus/infant
   - O Twins
   - O Triplets
   - O Quadruplets
   - O Don't Know

2. How many times have you been pregnant (including your current/recent pregnancy, previous pregnancies, live births, miscarriages, still births or abortions)? _____

3. How many of these pregnancies resulted in...(Enter "0", if not applicable)
    a. The live birth of an infant? _____

    b. A miscarriage _____

    c. An abortion _____

    d. The death of an infant at more than 20 weeks (or 5 months) of pregnancy, but before birth _____

    e. Other _____

If other, please specify:_____

4. ONLY ANSWERED BY women who have had at least 1 pregnancy that was live birth or death of an infant.

In prior pregnancies, have you had any of the following conditions occur (check all that apply):

- O Preterm birth (before 37 weeks of pregnancy are completed) of an infant→ go to 4a
- O Hemorrhage (major bleeding) after birth that required a blood transfusion
- O Diabetes during pregnancy
- O High blood pressure during pregnancy
- O Preeclampsia
- O Death of a fetus >20 weeks
- O Hospitalized during pregnancy → go to 4b
- O None of the Above

4a. How far along in the pregnancy was the infant born? ___weeks

4b. If you were hospitalized during pregnancy, please explain:
_____

5. For this current pregnancy, did you use any medications or procedures provided to you by a health care provider to become pregnant, such as in vitro fertilization (IVF)?
    - O Yes
    - O No

Alcohol, Drug and Tobacco Use

1. In the past 30 days, how often did you have a drink containing alcohol?
   - o Never **(skip to question 4)**
   - o Monthly or less
   - o 2 to 4 times a month
   - o 2 to 3 times a week
   - o 4 or more times a week
   - o Decline to state

2. In the past 30 days, how many drinks containing alcohol did you have on a typical day when you were drinking?
   One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.
   - o 1 or 2
   - o 3 or 4
   - o 5 or 6
   - o 7, 8, or 9
   - o 10 or more
   - o Decline to state

3. In the past 30 days, how often did you have 4 or more drinks on one occasion?
   - o Never
   - o Less than monthly
   - o Monthly
   - o Weekly
   - o Daily or almost daily
   - o Decline to state

4. Have you smoked 100 cigarettes (about 5 packs) or more in your entire life?
   - O Yes
   - O No
   - O Decline to state

5. Do you smoke cigarettes now?
   - O Yes
   - O No

6. Does anyone that you live with smoke cigarettes?
   - O Yes
   - O No
   - O Decline to state

7. In the past 30 days, have you vaped tobacco?
   - O Yes

- O No
- O Decline to state

8. In the past 30 days, how often did you use cannabis or marijuana?
   - O Never→ Go to Question 10
   - O Monthly or less
   - O 2 to 4 times a month
   - O 2 to 3 times a week
   - O 4 or more times a week
   - O Decline to state

9. In the past 30 days, have you vaped marijuana?
   - O Yes
   - O No
   - O Decline to state

10. In the past 30 days, did you use any of the following substances? *[Check all that apply]*
    - O Cocaine (coke, crack, etc.)
    - O Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)
    - O Methamphetamine (speed, crystal, ice, etc.)
    - O Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)
    - O Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB)
    - O Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy or Molly, etc.)
    - O Street opioids (heroin, opium, etc.)
    - O Prescription opioids as prescribed (fentanyl, oxycodone [Oxycontin, Percoset], hydrocodone [Vicodin], methadone, buprenorphine, etc)
    - O Prescription opioids without a prescription or differently from how they were prescribed (fentanyl, oxycodone [Oxycontin, Percoset], hydrocodone [Vicodin], methadone, buprenorphine, etc.
    - O Other (Specify) _____
    - O None of the above → Form Completed

11. In the past 30 days, how often did you use any of these substances [the substances from Q10]?
    - O Never
    - O Less than monthly
    - O Monthly
    - O Weekly
    - O Daily or almost daily
    - O Decline to state