Pregnancy Form

Are you currently pregnant?

- O Yes → QUESTIONNAIRE COMPLETED
- O No → go to 1a.
- O No but I have reported the details of my pregnancy (i.e., live birth, miscarriage) previously → form completed

1a. If no, when did the pregnancy end? _____ (date)

1b. If No, did the pregnancy end with…. (For multiples, i.e., twins, triplets, etc. mark all that apply):

- O Abortion? --> Go to Question 1d.
- O Miscarriage? --> Go to Question 1c.
- O Ectopic pregnancy? --> Go to Question 1f.
- O Molar pregnancy? --> QUESTIONNAIRE COMPLETED
- O Death of an infant or fetus >20 weeks (5 months) of pregnancy --> Go to Question 2
- O Live birth of an infant(s)? --> Go to Question 5 and complete Neonatal Form (Birth)

Miscarriage Questions:

1c. How far along in the pregnancy were you when the miscarriage occurred? _____ (in weeks from last menstrual period)

QUESTIONNAIRE COMPLETED

Abortion Questions:

1d. How far along in the pregnancy were you when the abortion occurred? _____ (in weeks from last menstrual period)

1e. What kind of abortion did you have? *Please select all that apply and remember, your answers will be kept confidential*

- O I had a surgical procedure at a clinic/health facility
- O I took pills → Complete below
- O I took herbs
- O I hit myself in the abdomen
- O I did something else
- O Decline to State

If you took pills or medication, where did you get the pills? *Select all that apply*.

- O I got pills from a clinic/health facility
- O I ordered pills on the internet
- O I got pills from a pharmacy
- O I got pills from someone else
- O Decline to state

QUESTIONNAIRE COMPLETED

Ectopic Pregnancy Questions:

1f. How was your ectopic pregnancy treated (check all that apply):

- O With methotrexate medication
- O With surgery
- O No treatment

QUESTIONNAIRE COMPLETED

Death of Infant or Fetus Questions:

2. How far along in the pregnancy were you when the infant(s) death occured? (in weeks from last menstrual period) ____

3. Did the infant(s) death occur:
   - O Prior to birth (still in the womb/uterus)
   - O During labor
   - O After delivery, within 6 weeks
   - O Other (specify below)

   Other, please specify: _____

4. What was the cause of the infant(s) death (check all that apply)?
   - O Unknown
   - O Infection
   - O Birth defect (e.g. congenital heart disease or other malformation)
   - O Other (specify below)

   Other, please specify: _____

Live Birth AND/OR Death of Infant or Fetus Questions:

5. Did you have any of the following conditions during pregnancy (check all that apply):
   - O Diabetes, pregnancy related (gestational diabetes)
   - O High blood pressure, pregnancy related (gestational hypertension)
   - O Preeclampsia (sometimes called "toxemia")
   - O Seizures
   - O Placenta previa (when the placenta covers the opening to the uterus, the cervix)
   - O Placenta abruption (when the placenta separates off from the uterus)
   - O Uterine rupture (when the wall of the uterus opens)
   - O Preterm premature rupture of membranes (when the bag of water breaks and at a time when the baby would be born premature)
   - O Abnormal amniotic fluid levels (oligohydramnios or polyhydramnios)
   - O Other (specify)
   - O None

   Other, please specify: _____

6. Did you take any medications regularly during your pregnancy besides prenatal vitamins or iron?
   - O Yes (please list below)
   - O No

   Please list medications: _____

7. Did you have any of the following conditions during or after the birth (check all that apply)
   - O Hemorrhage or excessive bleeding
   - O Blood transfusion
   - O Uterine Infection (also called chorioamnionitis or endometritis) during or after the birth
   - O Other (please explain below):
   - O None

   If Other pregnancy condition, please explain: _____

Neonatal Form (Birth)

1. Was your infant born at home?
   - O Yes → go to 3
   - O No

2. What is the name of the hospital or facility your infant was born at? _____

3. Did you receive prenatal care during your pregnancy?
   - O Yes, I had 6 or more prenatal visits
   - O Yes, I had 2-5 prenatal visits
   - O Yes, I had one prenatal visit
   - O No, I did not have a prenatal visit

4. What was your due date? _____

5. How many infants were born?

6. Was your infant/infants born breech presentation?
   - O Yes
   - O No
   - O I had twins, one was breech and one was not

7. Was your infant/infants born by:
   - O Vaginal delivery --> Go to Question 9
   - O Cesarean section --> Go to Question 8
   - O Vaginal delivery AND Cesarean section, for twins/other multiple births

8. If Cesarean section, what was the reason you had a Cesarean Section?
   - O Planned Cesarean section because I had a prior Cesarean Section
   - O Abnormal progress in labor
   - O Concern about your infant based on the heart monitor
   - O Baby was breech
   - O Uterine infection
   - O Emergency due to risk to baby or myself
   - O I was too sick to be in labor
   - O Other, please explain below

   8a. If Other reason for Cesarean section, please explain:
   _____

If Caesarean section only, go to Question 11

9. Was a vacuum (suction cup) used to try to deliver the baby?
   - O Yes
   - O No
   - O Don't Know

10. Were forceps used to try to deliver the baby?
   - O Yes
   - O No
   - O Don't Know

11. ***If multiples repeat Questions A - H for each infant born***

Please report infant information in the order of baby's birth from 1st to last (i.e., enter information for the baby who came first in the birth order under "Infant 1", the 2nd baby under "Infant 2", etc)

A. What is the infant's sex?
   - O Male
   - O Female

B. How much did the infant weigh at birth?

   Pounds: _____ (lbs (pounds))

   Ounces: _____ (oz (ounces))

C. Did you and your infant "room in" (share the same hospital room) while in the hospital?
   - O Yes → C1.
   - O No

C1. Did you take any precautions related to COVID-19 while sharing a room with your infant in the hospital, such as: (check all that apply)
   - O I wore a mask
   - O I washed my hands before caring for the infant
   - O There was a curtain or screen between me and my infant
   - O I did not care for the infant while in the hospital and others provided care
   - O No, I did not take any precautions related to COVID-19
   - O Other, please describe

D. Has the infant breastfed or received ANY breast milk?
   - O Yes → go to D1.
   - O No → got to E

D1. Did the infant breastfeed directly from your breast?
   - O Yes → go to D2.
   - O No → go to D6.

D2. How long after birth did you first try to breastfeed your infant?
   - O <30 min
   - O 30-60min

- O 60-120 min
- O 120 min-24 hours
- O After 24 hours

D3. Did you take any precautions related to COVID-19 during breastfeeding, such as: (check all that apply)

- O I wore a mask during breastfeeding
- O I washed my hands before breastfeeding
- O I washed my breasts before breastfeeding
- O No, I did not take any precautions related to COVID-19
- O Other, please describe: _____

D4. Are you currently breastfeeding your infant?

- O Yes→ got to E
- O No → go to D5

D5. What date did you stop breastfeeding your infant? _____→ go to E

D6. Did you provide expressed breast milk to your infant?

- O Yes → go to D7
- O No→ go to E

D7. Is your infant still receiving expressed breast milk?

- O Yes → go to E
- O No → go to D8

D8. What date did your infant last receive expressed breast milk? _____ → go to E

E. How long after birth was your infant placed skin-to-skin with you?

- O <30 min
- O 30-60min
- O 60-120 min
- O 120 min-24 hours
- O >24 hours
- O Infant was not placed skin-to-skin with me

F. Did your infant have any of the following problems during pregnancy labor, or delivery (check all that apply):

- O Baby diagnosed with COVID-19
- O Abnormal genetic screening (specify:_____)
- O Birth defect (specify:_____)
- O Fetal growth restriction (size was too small)
- O Meconium (brown stained fluid at the time of birth)
- O Other abnormalities (specify:_____)
- O None

G. Did your infant have any of the following problems after birth (check all that apply):

- O Baby diagnosed with COVID-19

- O Pneumonia
- O Received antibiotics
- O Abnormal genetic test (specify:_____)
- O Birth defect (specify:_____)
- O Fast breathing or difficulty breathing
- O Stopped breathing (apnea)
- O High heart rate
- O High temperature
- O Low temperature
- O Low blood sugar
- O High bilirubin level
- O Received antibiotics
- O Abnormal hearing screening test
- O Abnormal oxygen screening test
- O Seizure
- O Therapeutic hypothermia (cooling)
- O Abnormal bleeding or problem with blood clotting
- O Microcephaly (small head size for gestational age)
- O Abnormal findings on the newborn exam (specify:_____)
- O Problem with kidneys (specify:_____)
- O Problem with liver (specify:_____)
- O Problem with heart (specify:_____)
- O Other infection (specify:_____)
- O Other abnormalities (specify:_____)
- O None

H. Was your infant admitted to the neonatal intensive care unit (NICU)?
- O Yes → go to H1
- O No → Form Complete

H1. What is the name of the hospital where the infant was admitted to the NICU?
_____

H2. How many days was your infant in the neonatal intensive care unit? _____ (days (enter one whole number))

H3. Did your baby need oxygen or a breathing tube (ventilator) for respiratory support?
- O Yes → go to H4
- O No

H4. If yes, check all that apply:
- O Oxygen by nasal prongs (not connected to a separate machine to deliver pressure)
- O Positive airway pressure (CPAP), with or without extra oxygen) by nasal prongs or mask
- O Mechanical ventilation through breathing tube inserted into windpipe/trachea

H5a. Has your infant been discharged from the hospital?
- O Yes → Go to H5b

O No → Form complete

H5b. What date was your infant discharged from the hospital? _____

H6. When your infant left the hospital, where did the infant go?

O Home with mother
O Home without mother
O Other, please describe: _____