

Confidential Portion

38. Weight of Fetus	39. Obstetric estimate of Gestation (Completed Weeks)
40. Plurality – Single, Twin, Triplet, etc. (Specify)	41. If not Single Birth – Born First, Second, Third, etc.

Mother's Information

<p>42. Mother's Education - Check the box that best describes the highest degree or level of school completed at the time of delivery.</p> <p>1 <input type="checkbox"/> 8th grade or less (Specify): _____</p> <p>2 <input type="checkbox"/> 9th – 12th grade; no diploma</p> <p>3 <input type="checkbox"/> High school graduate or GED completed</p> <p>4 <input type="checkbox"/> Some college credit, but no degree</p> <p>5 <input type="checkbox"/> Associate degree(e.g., AA, AS)</p> <p>6 <input type="checkbox"/> Bachelor's degree(e.g., BA, AB, BS)</p> <p>7 <input type="checkbox"/> Masters degree(e.g., MA, MS, MEng, MEd, MSW, MBA)</p> <p>8 <input type="checkbox"/> Doctorate(e.g., PhD EdD) or Professional degree(e.g., MD, DDS, DVM, LLB, JD)</p>	<p>43. Mother of Hispanic Origin? Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check the "No" box if mother is not Spanish/Hispanic/Latina.</p> <p>0 <input type="checkbox"/> No, not Spanish/Hispanic/Latina</p> <p>1 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana</p> <p>2 <input type="checkbox"/> Yes, Puerto Rican</p> <p>3 <input type="checkbox"/> Yes, Cuban</p> <p>4 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify): _____</p>	<p>44. Mother's Race (Check one or more races to indicate what the mother considers herself to be)</p> <p>1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American</p> <p>3 <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____</p> <p>4 <input type="checkbox"/> Asian Indian 5 <input type="checkbox"/> Chinese</p> <p>6 <input type="checkbox"/> Filipino 7 <input type="checkbox"/> Japanese</p> <p>8 <input type="checkbox"/> Korean 9 <input type="checkbox"/> Vietnamese</p> <p>10 <input type="checkbox"/> Other Asian(Specify): _____</p> <p>11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro</p> <p>13 <input type="checkbox"/> Samoan</p> <p>14 <input type="checkbox"/> Other Pacific Islander(Specify): _____</p> <p>15 <input type="checkbox"/> Other(Specify): _____</p>										
45. Occupation (Indicate type of work done during last year.)	46. Kind of Business/Industry (Do not use Company Name)											
47. Mother Married? (At delivery, conception, or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Mother's Height Feet: _____ Inches: _____	49. Did Mother get WIC food for herself during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No										
50. Mother's Prepregnancy Weight (Pounds)	51. Mother's Weight at Delivery (Pounds)	52. Date Last Normal Menses Began (MM/DD/YYYY) _____ / _____ / _____										
53. Date of First Prenatal Care Visit (MM/DD/YYYY) _____ / _____ / _____ <input type="checkbox"/> No Prenatal Care	54. Date of Last Prenatal Care Visit (MM/DD/YYYY) _____ / _____ / _____	55. Total Number of Prenatal Visits for this Pregnancy (If none, enter '0') _____										
<p>56a. Number of Previous Live Births (Do not include this child)</p> <p>Now Living Number _____ <input type="checkbox"/> None</p> <p>Now Dead Number _____ <input type="checkbox"/> None</p>	<p>57a. Number of Other Pregnancy Outcomes (Spontaneous or induced losses or ectopic pregnancies)</p> <p>Other Outcomes Number _____ <input type="checkbox"/> None</p>	<p>58. Cigarette Smoking Before and During Pregnancy If none enter "0"</p> <p>Average number of cigarettes or packs per day:</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;"># of cigarettes</th> <th style="text-align: center;"># of packs</th> </tr> </thead> <tbody> <tr> <td>Three months before pregnancy</td> <td style="text-align: center;">OR</td> </tr> <tr> <td>First three months of pregnancy</td> <td style="text-align: center;">OR</td> </tr> <tr> <td>Second three months of pregnancy</td> <td style="text-align: center;">OR</td> </tr> <tr> <td>Last three months of pregnancy</td> <td style="text-align: center;">OR</td> </tr> </tbody> </table>	# of cigarettes	# of packs	Three months before pregnancy	OR	First three months of pregnancy	OR	Second three months of pregnancy	OR	Last three months of pregnancy	OR
# of cigarettes	# of packs											
Three months before pregnancy	OR											
First three months of pregnancy	OR											
Second three months of pregnancy	OR											
Last three months of pregnancy	OR											
59. Was mother transferred to higher level care for maternal medical or fetal indications for delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility mother was transferred from: _____												

Father's Information

<p>60. Father's Education-Check the box that best describes the highest degree or level of school completed at the time of delivery.</p> <p>1 <input type="checkbox"/> 8th grade or less (Specify): _____</p> <p>2 <input type="checkbox"/> 9th – 12th grade; no diploma</p> <p>3 <input type="checkbox"/> High school graduate or GED completed</p> <p>4 <input type="checkbox"/> Some college credit, but no degree</p> <p>5 <input type="checkbox"/> Associate degree(e.g., AA, AS)</p> <p>6 <input type="checkbox"/> Bachelor's degree(e.g., BA, AB, BS)</p> <p>7 <input type="checkbox"/> Masters degree(e.g., MA, MS, MEng, MEd, MSW, MBA)</p> <p>8 <input type="checkbox"/> Doctorate(e.g., PhD EdD) or Professional degree(e.g., MD, DDS, DVM, LLB, JD)</p>	<p>61. Father of Hispanic Origin? Check the box that best describes whether the father is Spanish/Hispanic/Latino or check the "No" box if father is not Spanish/Hispanic/Latino.</p> <p>0 <input type="checkbox"/> No, not Spanish/Hispanic/Latino</p> <p>1 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano</p> <p>2 <input type="checkbox"/> Yes, Puerto Rican</p> <p>3 <input type="checkbox"/> Yes, Cuban</p> <p>4 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify): _____</p>	<p>62. Father's Race (Check one or more races to indicate what the father considers himself to be)</p> <p>1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American</p> <p>3 <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____</p> <p>4 <input type="checkbox"/> Asian Indian 5 <input type="checkbox"/> Chinese</p> <p>6 <input type="checkbox"/> Filipino 7 <input type="checkbox"/> Japanese</p> <p>8 <input type="checkbox"/> Korean 9 <input type="checkbox"/> Vietnamese</p> <p>10 <input type="checkbox"/> Other Asian(Specify): _____</p> <p>11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro</p> <p>13 <input type="checkbox"/> Samoan</p> <p>14 <input type="checkbox"/> Other Pacific Islander(Specify): _____</p> <p>15 <input type="checkbox"/> Other(Specify): _____</p>
63. Occupation (Indicate type of work done during last year.)	64. Kind of Business/Industry (Do not use Company Name)	

Medical and Health Information

<p>65. Risk Factors in this Pregnancy (Check all that apply):</p> <p>1 Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy)</p> <p>2 Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia</p> <p>3 <input type="checkbox"/> Previous preterm birth</p> <p>4 <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)</p> <p>5 <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor</p> <p>6 <input type="checkbox"/> Pregnancy resulted from infertility treatment If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, artificial insemination or intrauterine insemination <input type="checkbox"/> Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)]</p> <p>7 <input type="checkbox"/> Mother had a previous cesarean delivery?</p>	<p>66. Method of Delivery</p> <p>A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other</p> <p>D. Final route and method of delivery (Check One) Vaginal: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum</p> <p>Or, Cesarean: <input type="checkbox"/> If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Hysterotomy/Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>67. Congenital Anomalies of the Fetus</p> <p>1 <input type="checkbox"/> Anencephaly</p> <p>2 <input type="checkbox"/> Meningocele / Spina bifida</p> <p>3 <input type="checkbox"/> Cyanotic congenital heart disease</p> <p>4 <input type="checkbox"/> Congenital diaphragmatic hernia</p> <p>5 <input type="checkbox"/> Omphalocele</p> <p>6 <input type="checkbox"/> Gastroschisis</p> <p>7 <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndrome)</p> <p>8 <input type="checkbox"/> Cleft Lip with or without Cleft Palate</p> <p>9 <input type="checkbox"/> Cleft Palate alone</p> <p>10 <input type="checkbox"/> Down Syndrome</p> <p><input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>11 <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed</p> <p><input type="checkbox"/> Karyotype pending</p> <p>12 <input type="checkbox"/> Hypospadias</p> <p>13 <input type="checkbox"/> None of the above</p>
<p>68. Maternal Morbidity (complication associated with labor and delivery) (Check all that apply):</p> <p>1 <input type="checkbox"/> Maternal transfusion</p> <p>2 <input type="checkbox"/> Third or fourth degree perineal laceration</p> <p>3 <input type="checkbox"/> Ruptured uterus</p> <p>4 <input type="checkbox"/> Unplanned hysterectomy</p> <p>5 <input type="checkbox"/> Admission to intensive care unit</p> <p>6 <input type="checkbox"/> Unplanned operating room procedure following delivery</p> <p>7 <input type="checkbox"/> None of the above</p>	<p>69. Infections Present and/or Treated During this pregnancy (Check all that apply):</p> <p>1 <input type="checkbox"/> Gonorrhea</p> <p>2 <input type="checkbox"/> Syphilis</p> <p>3 <input type="checkbox"/> Herpes Simplex Virus (HSV)</p> <p>4 <input type="checkbox"/> Chlamydia</p> <p>5 <input type="checkbox"/> Listeria</p> <p>6 <input type="checkbox"/> Group B Streptococcus</p> <p>7 <input type="checkbox"/> Cytomegalovirus</p> <p>8 <input type="checkbox"/> Parvovirus</p> <p>9 <input type="checkbox"/> Toxoplasmosis</p> <p>10 <input type="checkbox"/> HIV Infection</p> <p>11 <input type="checkbox"/> Other Specify: _____</p> <p>12 <input type="checkbox"/> None of the above</p>	

