

CRF – Obstetric Care and History		
No.	Question	Response
001	Enter today's date:	<p>— — / — — / — — — —</p> <p>D D / M M / Y Y Y Y</p>
002	Has the participant previously been pregnant?	0 = No Skip to 017 1 = Yes
003	Has the participant previously had a full-term birth (≥37 weeks gestation)?	0 = No Skip to 005 1 = Yes
004	Number of full-term births:	
005	Has the participant ever experienced preterm/premature births (<37 0/7 weeks)?	0 = No Skip to 007 1 = Yes
006	Number of preterm/premature births:	
007	Has the participant ever experienced pregnancy loss before 20 weeks gestation?	0 = No Skip to 009 1 = Yes
008	Number of pregnancy losses before 20 weeks gestation:	
009	Has the participant ever experienced pregnancy loss at or after 20 weeks gestation?	0 = No Skip to 011 1 = Yes
010	Number of pregnancy losses at or after 20 weeks gestation:	

011	Has the participant ever experienced neonatal loss (loss of infant within first 28 days of life)?	0 = No Skip to 013 1 = Yes
012	Number of neonatal losses (loss of infant within first 28 days of life):	
013	Has the participant ever been diagnosed with any of the following by their healthcare provider in a past pregnancy?	<p>Select all that apply</p> <p>If participant responded "Yes" to any of the above, please record these events in the Medical Events/Conditions CRF.</p> <p>0 = Hypertension/Hypertensive disorders 1 = Chorioamnionitis 2 = Puerperal sepsis 3 = Endometritis 4 = Antepartum hemorrhage 5 = Postpartum hemorrhage 6 = Preterm premature rupture of membranes (PPROM) 7 = Fever of undetermined etiology 8 = Other Specify in 014 9 = None of the above</p>
014	Please specify the 'other' complications:	<p>Respond only if [013 = 8]</p> <p>Please record these events in the Medical Events/Conditions CRF. TEXT ENTRY</p>
015	What is the participant's rhesus status?	<p>0 = Rh negative Document negative rhesus status in the Medical Events/Conditions CRF.</p> <p>1 = Rh positive</p>

016	Did the participant receive the Rho(D) immune globulin (Rhlg) shot (e.g., RhoGAM) with all past pregnancies?	0 = No 1 = Yes
017	Has the participant, or members of her family, ever been diagnosed with any of the following conditions?	0 = Cleft lip or palate 1 = Heart defect 2 = Spina bifida (open spine) 3 = Inherited muscle disease/muscular dystrophy 4 = Intellectual disability 5 = Down syndrome 6 = Cystic fibrosis 7 = Kidney disease 8 = Sickle cell anemia 9 = Hemophilia (bleeder's disease) 10 = Thalassemia (Mediterranean or Cooley's anemia) 11 = Other Specify in 018
018	Please specify other diagnosis/condition:	Respond only if [017 = 11]
019	Has the biological father, or members of his family, ever been diagnosed with any of the following conditions?	0 = Cleft lip or palate 1 = Heart defect 2 = Spina bifida (open spine) 3 = Inherited muscle disease/muscular dystrophy 4 = Intellectual disability 5 = Down syndrome 6 = Cystic fibrosis 7 = Kidney disease 8 = Sickle cell anemia 9 = Hemophilia (bleeder's disease) 10 = Thalassemia (Mediterranean or Cooley's anemia) 11 = Other Specify in 020

020	Please specify other diagnosis/condition:	Respond only if [019 = 11]
021	Has the participant been diagnosed with any of the following by their healthcare provider in this current pregnancy?	<p>Select all that apply</p> <p>If participant responded "Yes" to any of these options, please record these events in the Medical Events/Conditions CRF</p> <p>0 = Hypertension/Hypertensive disorders 1 = Chorioamnionitis 2 = Puerperal sepsis 3 = Endometritis 4 = Antepartum hemorrhage 5 = Postpartum hemorrhage 6 = Preterm premature rupture of membranes (PPROM) 7 = Fever of undetermined etiology 8 = Other Specify in 022 9 = None of the above</p>
022	Please specify the 'other' pregnancy complications:	Respond only if [021 = 8] Please record these events in the Medical Events/Conditions CRF.

023	Does the participant have a history of any of the following?	<p><i>Select all that apply</i></p> <p>If participant responded "Yes" to any of these options, please record these events in the Medical Events/Conditions CRF</p> <p>0 = Hypertension 1 = Asthma 2 = Heart disease 3 = Kidney disease 4 = Bleeding disorder 5 = Diabetes 6 = Obesity 7 = Seizures 8 = Substance use 9 = Hepatitis B virus infection 10 = Hepatitis C virus infection 11 = Autoimmune disease 12 = Thyroid disease 13 = Anxiety, depression, or other mental health condition</p>
024	Does the participant have a history of smoking?	<p>0 = No Skip to 026</p> <p>1 = Yes Document on the Medical Events and Conditions CRF</p>
025	Does the participant currently smoke cigarettes?	<p>0 = No</p> <p>1 = Yes Document on the Medical Events and Conditions CRF</p>
026	Has the participant ever consumed alcoholic beverages regularly (three or more drinks each week)?	<p>0 = No</p> <p>1 = Yes</p>
027	During this pregnancy has the participant consumed or currently consume alcoholic beverages?	<p>0 = No Skip to 029</p> <p>1 = Yes Document on the Medical Events and Conditions CRF</p>
028	During this pregnancy, how often did/does the participant drink alcoholic beverages? (less than once a month, once a month, weekly, daily)	<p>0 = Less than once a month 1 = About once a month 2 = Weekly 3 = Daily</p>

029	During this pregnancy or within the year leading up to this pregnancy does the participant report any exposures to toxic chemicals, substances, or materials such as work pollutants, contaminated water, pesticides, fertilizers, environmental toxins, cleaning agents?	0 = No Skip to 031 1 = Yes
030	Specify if participant reports exposure	Respond only if [029 = 1]
030	During this pregnancy has the participant ever used recreational or illicit drugs?	0 = No 1 = Yes Document on the Medical Events and Conditions CRF
030a	Specify drug use:	Respond only if [030 = 1]
031	Does the participant have any medications used during the pregnancy so far to report?	0 = No 1 = Yes Document on the Medications CRF
032	Has the participant used PEP during this pregnancy?	0 = No 1 = Yes Document on the Medications CRF
033	Is the participant currently receiving antenatal care?	0 = No 1 = Yes Document on the Healthcare Provider Form
034	Does the participant know where they plan to deliver?	0 = No 1 = Yes Document on the Healthcare Provider Form
035	Were any medical records reviewed? Note: document type in chart notes if yes	<i>Select all that apply</i> 0 = No 1 = Yes, handheld along with participant report 2 = Yes, abstracted from medical records

036	CRF Notes	
-----	-----------	--