GLOBAL ALLIANCE TO PREVENT PREMATURITY AND STILLBIRTH

The GAPPS Repository

# Data Dictionary

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# INTRODUCTION

## 1.1 GAPPS Data Management System

### *1.1.1 LabVantage*

LabVantage™ is a web-based data management system hosted by GAPPS.

#### 1.1.1.1 Participant Demographic Data

For participant level data, LabVantage™ stores and tracks participant demographic data, consent data, and delivery related data. Each participant is identified by the unique PTID number.

#### 1.1.1.2 Specimen Data

LabVantage™ stores and tracks all specimen related data including collection time data, storage data, and test results data. Each specimen is identified by a unique SCHID number, which can be linked to a single participant at a specific visit.

### *1.1.2 DatStat*

DatStat is a secure web application for designing and managing online surveys hosted at GAPPS.

#### 1.1.2.1 Questionnaires (Old Protocol)

Under the old GAPPS protocol, the GAPPS Repository collects 3 questionnaires via DatStat throughout the participant's pregnancy: Initial Visit Q, Second Trimester Q, and Postpartum Q.

### *1.1.3 REDCap*

REDCap is a secure web application for managing online surveys and data collections hosted at the University of Washington.

#### 1.1.3.1 Questionnaires (New Protocol)

Under the new GAPPS protocol, the GAPPS Repository collects 5 questionnaires via REDCap throughout the participant's pregnancy: Health History Q, Dietary Assessment Q, Review of Systems Q, Delivery and Discharge Q, and Follow Up Q.

#### 1.1.3.2 Medical Records Abstraction (MRA)

Medical record abstractions are abstracted by site coordinators and verified by site PIs. A verified MRA will be entered into the REDCap MRA project. The unique PTID number is the link between participants and MRAs.

### 1.2 Data Elements Summary

| Total number of: | **Old protocol** | **New protocol** |
|---|---|---|
| Data elements collected by GAPPS | 1735 | 961 |
| **Data elements break down** | | |
| Specimen level data elements | 56 | 56 |
| Participant level data elements | 1679 | 905 |
| **Participant level data elements break down** | | |
| Participant level data elements collected via LabVantage | 108 | 108 |
| Participant level data elements collected via MRA | 76 | 76 |
| Participant level data elements collected via Questionnaires | 1495 | 721 |

# 2 SPECIMEN DATA

### 2.1 Collections

The following data elements are collected from the Lab Requisition Forms.
The total number of data fields is 18.

| Data Element | Field Type |
|---|---|
| PTID (GAPPS unique ID for participant) | Text |
| SCHSpecimenID (GAPPS unique ID for specimen) | Text |
| Sample type | Text |
| Collection date | Date |
| Collection time | Time |
| Date rec'd in lab | Date |
| Time rec'd in lab | Time |
| Date processing complete | Date |
| Time processing complete (The time at which the aliquots are processed from the primary collections) | Time |
| Collected By | Text |
| Processed By | Text |
| Comments | Text |
| KitID | Text |
| Neonate Birth Order (Only applies to delivery specimens and neonate specimens) | Select one:<br>A; B; C; D; |
| NeonateID (Only applies to delivery specimens and neonate specimens) | Text, system calculates (PTID + Neonate Birth Order) |
| Blood drawn during Diabetes testing (Only applies to blood samples) | Yes/No |
| If during diabetes testing (If "Blood drawn during Diabetes testing" = Yes) | Select one:<br>Before testing;<br>After testing; |
| Was it done after Lubricant exam? (Only applies to Vaginal/Cerv-Vaginal swabs) | Yes/No |

## 2.2 Test Results

The following data elements are collected from the Lab QC Test Results.
The total number of data fields is 31.

| Data Element | Specimen Description | Field Type |
|---|---|---|
| Volume | Amnio Fluid<br>CBMC<br>PBMC<br>Whole Blood<br>Plasma<br>Serum<br>Whole Cord Blood<br>Cord Plasma<br>Cord Serum<br>Urine<br>DNA<br>RNA | Number |

| | | |
|---|---|---|
| 260 | Whole Blood DNA<br>Flash Frozen Tissue RNA<br>RNAltr Plcnta Punch RNA | Number |
| 280 | Whole Blood DNA<br>Flash Frozen Tissue RNA<br>RNAltr Plcnta Punch RNA | Number |
| 260/280 | Whole Blood DNA<br>Flash Frozen Tissue RNA<br>RNAltr Plcnta Punch RNA | Number |
| RIN | RNAltr Plcnta Punch RNA | Number |
| Yield | Whole Blood DNA<br>Flash Frozen Tissue RNA<br>RNAltr Plcnta Punch RNA | Number |
| Concentration | Whole Blood DNA<br>Flash Frozen Tissue RNA<br>RNAltr Plcnta Punch RNA | Number |
| Base Pairs (uncut) | Whole Blood DNA | Number |
| Base Pairs (average, cut) | Whole Blood DNA | Number |
| Paraffin Embedding | Plcnta A<br>Plcnta B<br>Cord<br>Membrane | Pass/Fail |
| Fetal Aspect | Plcnta A/Plcnta B | Pass/Fail |
| Maternal Aspect | Plcnta A/Plcnta B | Pass/Fail |
| Amnion/Chorion | Plcnta Membrane | Pass/Fail |
| Separation | Plcnta Membrane | Pass/Fail |
| Vessels | Plcnta Cord | Pass/Fail |
| Cut | Plcnta Cord | Pass/Fail |
| IRV | CBMC/PBMC | Number |
| Vol. Cells Stained | CBMC/PBMC | Number |
| Vol. Trypan blue | CBMC/PBMC | Number |
| Trypan DF | CBMC/PBMC | Number |
| Live Cells | CBMC/PBMC | Number |
| Dead Cells | CBMC/PBMC | Number |
| % Viable Cells | CBMC/PBMC | Number |
| Haemocyt. Vol. | CBMC/PBMC | Number |
| Total Viable Cells | CBMC/PBMC | Number |
| Resuspension Vol. | CBMC/PBMC | Number |
| Mr. Frosty Date | CBMC/PBMC | Date |
| Mr. Frosty Time | CBMC/PBMC | Time |
| LN2 Date | CBMC/PBMC | Date |
| LN2 Time | CBMC/PBMC | Time |
| FBS/HS lot no. | CBMC/PBMC | Text |

### 2.3 Additional Data

The following data elements are collected from LabVantage.
The total number of data fields is 7.

| Data Element | Field Type |
|---|---|
| Visit (The time period for collections) | Text, system calculates<br>Examples:<br>1st trimester;<br>2nd trimester;<br>3rd trimester;<br>Delivery; |
| GA at collection (weeks _/7 days) | Number, system calculates |
| Freezer location (Where in the freezer the specimens are put) | Text |
| Sample status | Text, examples:<br>In Circulation;<br>3rd Party Transfer;<br>Disposed; |
| Date distributed (If "Sample status" = "3rd Party Transfer") | Date |
| Distributed to (If "Sample status" = "3rd Party Transfer") | Text |
| Freeze Thaw count | Number |

## 3 PARTICIPANT DATA (LABVANTAGE)

### 3.1 Primary Participant's Demographic Data

The following data elements are collected from the Primary Participant Enrollment Form and Consent Forms.
The total number of data fields is 51.

| Data Element | Field Type |
|---|---|
| PTID (GAPPS unique ID for participant) | Text |
| Age | Number |
| Race | Check all that apply (see Race option table) |
| Ethnicity | Select One (see Ethnicity option table) |
| Country of Origin | Text |
| Country of Birth | Text |
| Language Spoken | Text |
| FOB Race (Father of baby information) | Check all that apply (see Race option table) |
| FOB Ethnicity | Select One (see Ethnicity option table) |
| FOB Country of Origin | Text |
| FOB Country of Birth | Text |

| | |
|---|---|
| FOB Language Spoken | Text |
| Primary's Mother's Race (Participant's mother's information) | Check all that apply (see Race option table) |
| Primary's Mother's Ethnicity | Select One (see Ethnicity option table) |
| Primary's Mother's Country of Origin | Text |
| Primary's Mother's Country of Birth | Text |
| Primary's Mother's Language Spoken | Text |
| Primary's Father's Race (Participant's father's information) | Check all that apply (see Race option table) |
| Primary's Father's Ethnicity | Select One (see Ethnicity option table) |
| Primary's Father's Country of Origin | Text |
| Primary's Father's Country of Birth | Text |
| Primary's Father's Language Spoken | Text |
| FOB's Mother's Race (FOB's mother's information) | Check all that apply (see Race option table) |
| FOB's Mother's Ethnicity | Select One (see Ethnicity option table) |
| FOB's Mother's Country of Origin | Text |
| FOB's Mother's Country of Birth | Text |
| FOB's Mother's Language Spoken | Text |
| FOB's Father's Race (FOB's father's information) | Check all that apply (see Race option table) |
| FOB's Father's Ethnicity | Select One (see Ethnicity option table) |
| FOB's Father's Country of Origin | Text |
| FOB's Father's Country of Birth | Text |
| FOB's Father's Language Spoken | Text |
| **Below is consent information for primary participants.** | |
| Consent to collect blood | Yes/No |
| Consent to store my DNA | Yes/No |
| Consent to store my RNA | Yes/No |
| Consent to collect cerv-vag swabs | Yes/No |
| Consent to collect vaginal swab | Yes/No |
| Consent to collect urine | Yes/No |
| Consent to collect amniotic fluid | Yes/No |
| Consent to collect placenta | Yes/No |
| Consent to collect cord blood | Yes/No |
| Consent to store cord blood | Yes/No |
| Consent to store cell line | Yes/No |
| Consent to collect meconium | Yes/No |
| Consent to collect neonate urine | Yes/No |
| Consent to store baby DNA | Yes/No |
| Consent to store baby RNA | Yes/No |

| | |
|---|---|
| Consent to store my samples | Yes/No |
| Consent to request my MR | Yes/No |
| Consent to request baby MR | Yes/No |
| Consent to future study contact | Yes/No |

Selection options for data element – **Race**:

| | | |
|---|---|---|
| White – Europe | AI/AN – Canadian Indian | Asian – Unlisted |
| White - Middle East | AI/AN – French American Indian | Asian – Unknown |
| White - North Africa | AI/AN – Spanish American Indian | NH/PI – Native Hawaiian |
| White - Unlisted | AI/AN – Unlisted | NH/PI – Samoan |
| White – Unknown | AI/AN – Unknown | NH/PI – Guamanian or Guamorro |
| Black or African American | Asian – Asian Indian | NH/PI – Unlisted |
| AI/AN – Original peoples of N, Central or S America | Asian – Filipino | NH/PI – Unknown |
| AI/AN – Navajo | Asian – Korean | Unlisted Race |
| AI/AN – Blackfeet | Asian – Chinese | Unknown Race |
| AI/AN – Inupiat | Asian – Vietnamese | I'd Rather Not say |
| AI/AN – Yupik | Asian – Japanese | |

Selection options for data element – **Ethnicity**:

| | |
|---|---|
| Hispanic - Mexico (including Mexican-American Chicano/Chicana) | Not Spanish/Hispanic/Latino/Latina |
| Hispanic - Puerto Rico | Unknown Ethnicity |
| Hispanic - Cuba | I'd Rather Not Say |
| Hispanic - Unlisted Central American Spanish-speaking country | |
| Hispanic - Spanish-speaking country of South America | |
| Hispanic - Unlisted Spanish cultures | |

## 3.2 Primary Participant's Delivery Data

The following data elements are collected from LabVantage's "Edit Participant" screen "Delivery Info" tab.

The total number of data fields is 17.

| **Data Element** | **Field Type** |
|---|---|
| Placenta Collected? | Yes/No |
| Cord blood Collected? | Yes/No |
| Reason not collected? (If "Placenta Collected?" = No or "Cord blood Collected?" = No) | Select one:<br>Notification;<br>Operation;<br>Participants;<br>GAPPS Personnel;<br>Clinic Personnel;<br>Unique Event; |

| | |
|---|---|
| Delivery date | Date |
| Number of babies | Number |
| Placenta Weight Method | Select one:<br>Pathology fresh;<br>Pathology fixed;<br>Site measured;<br>Not weighed; |
| Placenta A Weight (gm) | Number |
| Placenta B Weight (gm) | Number |
| Baby A gender | Male/Female |
| Baby A birth weight (gm) | Number |
| If fetal/neonatal loss for baby A, reason | Select one (see Fetal/neonatal loss option table) |
| Baby B gender | Male/Female |
| Baby B birth weight (gm) | Number |
| If fetal/neonatal loss for baby B, reason | Select one (see Fetal/neonatal loss option table) |
| Baby C gender | Male/Female |
| Baby C birth weight (gm) | Number |
| If fetal/neonatal loss for baby C, reason | Select one (see Fetal/neonatal loss option table) |

Selection options for data element – **Fetal/neonatal loss**:

| | |
|---|---|
| Fetal loss before 20 weeks (SAB/Miscarriage); | Fetal loss after 20 weeks (Stillbirth); |
| Therapeutic abortion; | Selective reduction; |
| Neonate Demise; | Undefined; |

## 3.3 Primary Participant Exit Study Data

The following data elements are collected from LabVantage's "Edit Participant" screen "Exit Study" tab.

The total number of data fields is 3.

| **Data Element** | **Field Type** | **Select Options** |
|---|---|---|
| Exit study date | Date | |
| Exit reason | Select one | Participant withdrew self;<br>Ineligible participant;<br>Other; |
| Additional Information (If "Exit reason = "Other") | Text | |

## 3.4 Family Member Data

The following data elements are collected from the Family Member Enrollment Form.

The total number of data fields is 41.

| Data Element | Field Type |
|---|---|
| PTID (GAPPS unique ID for participant) | Text |
| Enroll date | Date |
| Participant type | Select one:<br>Adult family member;<br>Child family member; |
| Relationship to primary | Select one:<br>Father of baby;<br>Mother;<br>Son;<br>Daughter;<br>Full sister;<br>Son of full sister;<br>Daughter of full sister; |
| Age (age in month or year) | Number |
| Race | Check all that apply:<br>American Indian/Native American;<br>Asian;<br>Black;<br>Native Hawaiian/Pacific Islander;<br>White;<br>Unknown; |
| Ethnicity | Select One:<br>Not Hispanic;<br>Hispanic;<br>Declined to report; |
| What is your maternal grandmother's (your mom's mom) Country of Origin? | Text |
| What is your maternal grandfather's (your mom's dad) Country of Origin? | Text |
| What is your paternal grandmother's (your dad's mom) Country of Origin? | Text |
| What is your paternal grandfather's (your dad's dad) Country of Origin? | Text |
| Consent to store RNA | Yes/No |
| Consent to store DNA | Yes/No |
| Consent to collect buccal swab | Yes/No |
| Do you have a childhood onset/longstanding disorder? | Yes/No |
| Disorder type (If "Do you have a childhood onset/longstanding disorder" = Yes) | Text |
| Diagnosis age (If "Do you have a childhood onset/longstanding disorder" = Yes) | Number |
| Does a close family member (ex. Mom, dad, grandma, son, etc) have a childhood onset/longstanding disease? | Yes/No |

| | |
|---|---|
| Please list family relation (ex. Mom, dad, grandma, son, etc) (If "Does a close family member have a childhood onset/longstanding disease"= Yes) | Text |
| Family member disorder type (If "Does a close family member have a childhood onset/longstanding disease" = Yes) | Text |
| **The following data elements are collected for women ONLY.** | |
| Have you ever been pregnant? | Yes/No |
| Have you ever delivered a baby preterm (preterm is before 37 weeks)? (If "Have you ever been pregnant" = Yes) | Yes/No |
| Preterm birth DOB (If "Have you ever delivered a baby preterm" = Yes) | Date |
| Gestational Age (GA) at preterm birth (If "Have you ever delivered a baby preterm" = Yes) (weeks _/7 days) | Number |
| Have you ever experienced a non planned fetal loss? (Do not include elective abortions.) (If "Have you ever been pregnant" = Yes) | Yes/No |
| GA at fetal loss (If "Have you ever experienced a non planned fetal loss" = Yes) (weeks _/7 days) | Number |
| Have you ever experienced any of the following during any of your pregnancies: | |
| Gestational diabetes? | Yes/No |
| Vaginal bleeding? | Yes/No |
| Pregnancy induced hypertension? | Yes/No |
| Preeclampsia? | Yes/No |
| Eclampsia/HELLP syndrome? | Yes/No |
| Blood incompatibility? | Yes/No |
| Multiple pregnancy? | Yes/No |
| Severe vomiting requiring hospitalization? | Yes/No |
| Preterm rupture of membranes or preterm labor without delivery? | Yes/No |
| Fetal distress? | Yes/No |
| Suspected impaired fetal growth or small baby for gestational age? | Yes/No |
| Stillbirth? | Yes/No |
| Infection requiring antibiotic treatment? | Yes/No |
| Other pregnancy related condition? | Yes/No |
| Other pregnancy related condition spec (If "Other pregnancy related condition" = Yes) | Text |

# 4 PARTICIPANT MEDICAL RECORDS DATA

## 4.1 Medical Records Abstraction Data

The following data elements are collected from the Medical Records Abstraction stored in REDCap.

The total number of data fields is 76.

| Data Element | Field Type |
|---|---|
| PTID (GAPPS unique ID for participant) | Text |
| Consent to maternal MR? | Yes/No |
| Consent to neonatal MR? | Yes/No |
| Date of Abstraction | Date |
| Abstracted by | Text |
| Verified by | Text |
| Study Exit | Yes/No |
| Exit reason (If "Study Exit" = Yes) | Text |
| Mom Age | Number |
| Mom Race | Check all that apply:<br>American Indian/Alaska Native;<br>Asian;<br>Native Hawaiian or Other Pacific Islander;<br>Black or African American;<br>White;<br>Unknown/Not Reported; |
| Mom Ethnicity | Select one:<br>Hispanic or Latino;<br>Not Hispanic or Latino;<br>Unknown/Not Reported; |
| Delivery Date | Date |
| GA week at delivery | Number |
| GA day at delivery | Number |
| Method used to determine GA | Select one:<br>LMP;<br>Ultrasound;<br>Unknown; |
| Assisted Conception | Yes/No |
| Assisted Type (If "Assisted Conception" = Yes) | Check all that apply:<br>Ovulation;<br>Induction;<br>IVF;<br>Donor Sperm;<br>Donor Egg;<br>Surrogacy;<br>Not specified; |
| Mom Height (inches) | Number |
| Mom first documented weight (lbs.) | Number |
| Mom last documented weight (lbs.) | Number |
| Mother medical history | Check all that apply (see Mother Medical History options table) |
| Other mother medical history (If "Mother medical history" = "Other") | Text |

| | |
|---|---|
| Mother medical history notes | Text |
| Mom Gravidity | Number |
| Number of Prior Term Births | Number |
| Number of Prior Preterm Births | Number |
| Prior PTB GA 1 | Number |
| Prior PTB GA 2 | Number |
| Fetal loss before 20 wks | Number |
| Therapeutic abortions | Number |
| Fetal loss 20 wks or later | Number |
| Neonatal deaths | Number |
| Reproductive history notes | Text |
| Mother Past Obstetrical Complications | Check all that apply (see Mother Past Obstetrical Complications options table) |
| Other mother past obstetrical complications (If "Mother Past Obstetrical Complications" = "Other") | Text |
| Mother past obstetrical complication notes | Text |
| Maternal Category | Check all that apply (see Maternal Category options table) |
| Obese – BMI (If "Maternal Category" = "Obese" or "Morbidly Obese") | Number |
| Specify preterm labor treatment drug use (If "Maternal Category" = "Preterm labor treatment") | Check all that apply:<br>Terbutaline;<br>Magnesium sulfate;<br>Nifedipine;<br>Indomethacin;<br>Corticosteroids;<br>Antibiotics, SPECIFY;<br>OTHER, SPECIFY; |
| Specify antibiotics (If "Specify preterm labor treatment drug use" = "antibiotics") | Text |
| Other drug use (If "Specify preterm labor treatment drug use" = "Other") | Text |
| Multiple Gestation (If "Maternal Category" = "Multiple Gestation") | Select one:<br>Twin;<br>Triplet;<br>Other; |
| Other multiple gestation (If "Multiple Gestation" = "Other") | Text |
| Specify fetal anomaly/chromosomal disorder (If "Maternal Category" = "Fetal anomaly/chromosomal disorder") | Text |
| Specify serology positive (If "Maternal Category" = "Serology positive") | Text |

| | |
|---|---|
| Monoamniotic/Diamniotic | Check all that apply:<br>Monoamniotic;<br>Diamniotic;<br>Monochorionic;<br>Dichorionic; |
| Diabetes – Type | Select one:<br>Type I;<br>Type II;<br>Gestational;<br>Hybrid;<br>MODY; |
| Diabetes – Treatment | Select one:<br>Insulin;<br>Oral meds;<br>Diet;<br>Not specified; |
| Other Maternal Category (If "Maternal Category" = "Other") | Text |
| If fetal/neonatal loss | Select one (see Fetal/neonatal loss options table) |
| Pregnancy notes | Text |
| Type of labor | Select one:<br>Spontaneous;<br>Augmented;<br>Induced-Complication;<br>Induced-Elective;<br>No Labor; |
| Delivery type | Check all that apply:<br>Normal/Spontaneous;<br>Cesarean;<br>Forceps;<br>Vacuum; |
| Cesarean delivery indication (If "Delivery type" = "Cesarean") | Check all that apply (see Cesarean Delivery Indication options table) |
| Characteristics of labor/delivery | Check all that apply (see Characteristics of labor/delivery options table) |
| **The following newborn data elements are collected for each newborn.** | |
| Gender | Male/Female |
| Weight (gm) | Number |
| Size | Normal/SGA/LGA |
| Head circumference (cm) | Number |
| Apgar score 1 min | Number |
| Apgar score 5 min | Number |
| Apgar score 10 min | Number |
| Complications of newborn at delivery | Check all that apply (see Complications of newborn at delivery options table) |

| | |
|---|---|
| Other complications of newborn at delivery (If "Complications of newborn at delivery" = "Other") | Text |
| Admitted to intensive care? | Yes/No |
| Diagnosis or treatment prior to discharge | Check all that apply (see Diagnosis or treatment prior to discharge options table) |
| Specify Chromosomal disorder (If "Diagnosis or treatment prior to discharge" = "Chromosomal disorder") | Text |
| Specify congenital anomaly (If "Diagnosis or treatment prior to discharge" = "Congenital anomaly") | Text |
| Other Diagnosis or treatment prior to discharge (If "Diagnosis or treatment prior to discharge" = "Other") | Text |
| **The following placenta data elements are collected for each placenta.** | |
| Path report available | Yes/No |
| Weight (gm) | Number |
| Weight method | Fixed/Fresh |
| Size | Normal/SGA/LGA |
| Placenta Category | Check all that apply (see Placenta Category options table) |
| Specify umbilical cord abnormality (If "Placenta Category" = "Umbilical cord abnormality") | Text |
| Other category (If "Placenta Category" = "Other") | Text |

Selection options for data element – **Mother Medical History**:

| | | |
|---|---|---|
| None | Cancer or other malignancy | Prior sexually transmitted disease |
| Asthma | Endometriosis | Renal disease |
| Cardiac Disease | Hematologic condition, SPECIFY | Rheumatoid Arthritis |
| Chlamydia | Hepatitis | Seizure disorder |
| Chronic Hypertension | HIV or AIDS | Thyroid disease |
| Chronic respiratory disease | Lupus erythematous | Ulcerative colitis |
| Crohn's disease | Mental illness (depression, anxiety) | OTHER, SPECIFY |
| Celiac disease | Migraines | |

Selection options for data element – **Mother Past Obstetrical Complications**:

| | | |
|---|---|---|
| None | Preterm labor without delivery | Non-Cesarean uterine surgery |
| Cervical insufficiency | Preterm delivery | Chorioamnionitis |
| Endometriosis | PROM | GBS |
| Endometritis | Vaginal bleeding | Maternal Substance Abuse |
| GDM | Preeclampsia | Methadone Treatment |
| Pregnancy induced hypertension | Eclampsia/HELLP | OTHER, SPECIFY |
| Impaired fetal growth / SGA | Fetal complication | |
| Multiple Gestations | Fetal anomaly | |

Selection options for data element – **Maternal Category**:

| | | |
|---|---|---|
| Normal | Fetal anomaly/Chromosomal disorder, SPECIFY | Preeclampsia/eclampsia |
| Abnormal Pap | Followed for size | Premature rupture of membranes (PROM) |
| Anemia (hematocrit< 30) | Antenatal Small for Gestational Age | Preterm delivery |
| Antepartum hemorrhage | GBS | Preterm labor treatment, SPECIFY DRUG |
| Asthma | Gonorrhea | Preterm labor without delivery |
| Autoimmune disease | Herpes (HSV) | Respiratory infection requiring antibiotics |
| Bacterial Vaginosis | Hyperemesis (severe vomiting/nausea/weight loss) | Rh negative |
| Candida yeast | Obese (BMI of 30-39), SPECIFY BMI | Serology positive, SPECIFY |
| Cardiac disease | Morbidly Obese (BMI >= 40), SPECIFY BMI | Smoker |
| Cervical insufficiency | Thrombophilia | Spontaneous loss |
| Cerclage | Multiple gestation, SPECIFY | Thyroid disease |
| Chlamydia | Oligohydramnios | Trichomonas |
| Chronic Hypertension | Polyhydramnios | Twin-twin transfusion |
| Depression | Placental abruption | UTI requiring antibiotics |
| Endometriosis | Placenta Accreta | Vaginal bleeding 1st trimester |
| Endometritis | Poor biophysical parameters | Vaginal bleeding 2nd trimester |
| Anxiety | Pregnancy induced hypertension | Vaginal bleeding 3rd trimester |
| OTHER, SPECIFY | | |

Selection options for data element – **Fetal/neonatal loss**:

| | |
|---|---|
| Fetal loss before 20 weeks (SAB/Miscarriage); | Fetal loss after 20 weeks (Stillbirth); |
| Therapeutic abortion; | Selective reduction; |
| Neonate Demise; | Undefined; |

Selection options for data element – **Cesarean Delivery Indication**:

| | | |
|---|---|---|
| N/A | Multiple Gestation | Planned Tubal Ligation |
| Repeat | CPD/FTP | Amnionitis |
| Fetal Position | Previa/Abruption | Active Herpes |
| Fetal Distress | Failed Induction | Prolapsed Cord |
| OTHER, SPECIFY | | |

Selection options for data element – **Characteristics of Labor/Delivery**:

| | |
|---|---|
| None | Prolonged rupture of membranes (>12hrs) |
| Antibiotics received by mother during labor | Placental abruption |
| Fetal distress | Non-vertex presentation |
| Meconium staining of amniotic fluid | Precipitous Labor (< 3 hrs) |

| | |
|---|---|
| Steroids for fetal lung maturation prior to delivery | OTHER, SPECIFY |

Selection options for data element – **Complications of Newborn at delivery**:

| | |
|---|---|
| None | Antibiotic received by newborn suspected sepsis |
| Nonviable | Nuchal cord |
| Assisted ventilation required for > 6 hrs | OTHER, SPECIFY |
| Newborn given surfactant replacement therapy | |

Selection options for data element – **Diagnosis or Treatment prior to discharge**:

| | | |
|---|---|---|
| None | Mechanical ventilation | TPN |
| Bronchopulmoary dysplasia | Meconium Aspiration | Transient tachypnea |
| Chromosomal disorder, SPECIFY | Metabolic Disorder | Sepsis |
| Congenital anomaly, SPECIFY | Necrotizing entercolitis | Pneumonia |
| Hyperbilirubinaemia | Neonatal sepsis | Discharged on Human Milk |
| Hypoglycemia | Respiratory distress syndrome | OTHER, SPECIFY |
| IVH | Retinopathy of prematurity | |

Selection options for data element – **Placenta Category**:

| | | |
|---|---|---|
| None | Advanced villous maturation | Infarction, SPECIFY %Mass |
| Abruption | Changes of Preeclampsia/PIH | Increased intervillous fibrin |
| Acute Chorioamnionitis - Mild | Chronic Villitis | Meconium |
| Acute Chorioamnionitis - Moderate | Delayed Villous Maturation | Umbilical Cord Abnormality, SPECIFY |
| Acute Chorioamnionitis - Severe | Fetal Thrombotic Vasculopathy | OTHER, SPECIFY |

# 5 PARTICIPANT QUESTIONNAIRE DATA (OLD PROTOCOL)

NOTES:
All data elements collected by questionnaires have options with “I don’t know” and “I’d rather not say”.

## 5.1 Basic Info

The following data elements are collected from the Initial Visit Q – Basic Info and “More About You” section.
The total number of data fields is 16.

| Data Element | Field Type |
|---|---|
| Age | Number |
| Height (By feet, inches) | Number |
| Weight before pregnancy (By pounds) | Number |
| Age at first menstrual period | Number |

| | |
|---|---|
| Days of menstrual cycle | Number |
| Born in US | Yes/No |
| Birth place spec (If "Born in US" = No) | Text |
| Language | Text |
| Highest grade of education | Select one |
| ○ 8th grade or less<br>○ 9th-11th grade<br>○ High school graduate or equivalent (*GED*)<br>○ Some college, but no degree or certificate<br>○ Technical or vocational school graduate<br>○ Bachelor's degree<br>○ Graduate or professional degree | |
| Income source | Check all that apply |
| ○ Wages and salaries, including self-employment, business, and farm income<br>○ Interest-bearing checking accounts, savings accounts, IRAs or certificates of deposit, money market funds, treasury notes, bonds, or other investments that earned interest, dividends received from stocks or mutual funds, or net rental income from property, royalties, estates or trusts<br>○ Social security, Railroad Retirement, Workers' compensation, disability, veteran benefits, or pensions<br>○ Family or friends<br>○ Unemployment benefits<br>○ Child support or alimony<br>○ Aid such as Temporary Assistance for Needy Families (TANF), welfare, WIC, public assistance, general assistance, food stamps, or Supplemental Security Income<br>○ Any other source, SPECIFY | |
| Other income source spec (If "Other income source" checked) | Text |
| Total family income | Select one |
| ○ Options:<br>○ Less than $20,000 / $20,000 – $29,999 / $30,000 – $39,999 / $40,000 – $49,999 / $50,000 – $59,999 / $60,000 – $69,999 / $70,000 – $79,999 / $80,000 or more | |
| # of adults supported by this income | Number |
| # of children supported by this income | Number |
| Health insurance type | Select one |
| ○ Insurance through a current or former employer or union (of yourself or another family member)<br>○ Insurance purchased directly from an insurance company (by yourself or another family member)<br>○ Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability (for example, First Steps, Basic Health Plan)<br>○ TRICARE, VA, or other military health care<br>○ Indian Health Service<br>○ Medicare, for people 65 and older, or people with certain disabilities<br>○ Other type of health insurance or health coverage plan, SPECIFY<br>○ None | |
| Marital status | Select one |

| |
|---|
| ○ Married<br>○ Engaged<br>○ Single, never married<br>○ Divorced<br>○ Separated<br>○ Widowed<br>○ Living with |

## 5.2 Reproductive History

The following data elements are collected from the Initial Visit Q – "Reproductive History" section.

The total number of data fields is 1 + 11 x 3 + 9 x 3 = 61 (based on 3 pregnancies, singleton).

| **Data Element** | **Field Type** |
|---|---|
| # of pregnancies | Number |
| **The following data elements are collected for each previous pregnancy.** | |
| Age at pregnancy | Number |
| Used fertility drugs | Yes/No |
| Fertility drugs spec (If "Used fertility drugs" = Yes) | Text |
| # of fetuses | Number |
| Medical condition during pregnancy | Select one |
| ○ Premature *or* Preterm Labor<br>○ Bacterial Vaginosis (*fishy smelling vaginal discharge treated with flagyl or metronidazole*)<br>○ Diabetes mellitus (*diagnosed prior to pregnancy*)<br>○ Sexually Transmitted Disease *or* Infection (*i.e. Chlamydia, syphilis, trichamonas, or gonorrhea*)<br>○ High Blood Pressure (*hypertension*)<br>○ Gestational Diabetes (*diabetes that is diagnosed for the first time during pregnancy*)<br>○ Premature Rupture of Membranes (*bag of water breaks before labor starts*)<br>○ Preeclampsia, Eclampsia, *or* Toxemia<br>○ Anemia (*low blood count)*<br>○ RH Disease or Isommunization (*mother develops antibodies to the fetus' blood type*)<br>○ Urinary Tract Infection (*bladder or kidney infection*)<br>○ Other Pregnancy-Related Condition SPECIFY<br>○ None | |
| Other medical condition during pregnancy spec (If "Other medical condition during pregnancy" checked) | Text |
| # of weeks pregnancy ended | Number |
| Is a live birth | Yes/No |
| Delivery method | Select one |
| ○ Vaginal Delivery<br>○ Assisted Vaginal (Forceps or Vacuum)<br>○ Cesarean Section | |
| Why C-section (If "Cesarean section" checked) | Select one |

| | |
|---|---|
| ○ Cervix Stopped Dilating (*failure to make progress in labor, often because the baby is too large for the pelvis*)<br>○ Fetal Distress (*abnormal fetal heart rate*)<br>○ Twins or Triplets (*or other multiple births*)<br>○ Breech or Other Fetal Positioning making Vaginal Delivery Difficult (*baby is not positioned with its head down*)<br>○ My Own Choice (*elective*)<br>○ Other, SPECIFY | |
| Other C-section reason (If "Why C-section = "Other") | Text |
| Is LBW for full term | Yes/No |
| Has birth defect | Yes/No |
| Birth defect type | Select one |
| ○ Congenital heart defect<br>○ Cleft lip or cleft palate<br>○ Sickle cell disease<br>○ Spina bifida, anencephaly, other neural tube defect<br>○ Limb defect (*club foot*)<br>○ Fetal alcohol syndrome<br>○ Cystic fibrosis<br>○ Abdominal wall defects (*gastroschisis, omphalocele, diaphragmatic hernia*)<br>○ Hypospadias<br>○ Down syndrome<br>○ Other congenital or genetic disease SPECIFY | |
| Other birth defect type spec (If "Other birth defect type" checked) | Text |
| Is baby alive | Yes/No |
| Age at death (If "Is baby alive" = No) | Number |
| Cause of death | Select one |
| ○ Birth defect(s)<br>○ Infection (*for example, pneumonia, sepsis, meningitis*)<br>○ Breathing problems (*respiratory distress syndrome, Broncho pulmonary dysplasia*)<br>○ Preterm birth<br>○ SIDS (*sudden infant death syndrome, crib death*)<br>○ Injuries<br>○ Complications from labor and delivery (*birth asphyxia*)<br>○ Other SPECIFY | |
| Other cause of death spec (If "Other cause of death" checked) | Text |
| Pregnancy outcome | Select one |
| ○ Miscarriage<br>○ Ectopic or tubal (*pregnancy implanted into the fallopian tube and was treated with surgery or medication to end the pregnancy*)<br>○ Stillborn (*death of the fetus inside the uterus*)<br>○ Abortion (*elective termination of pregnancy*)<br>○ Other *SPECIFY* | |
| Other pregnancy outcome spec (If "Other pregnancy outcome" checked) | Text |

## 5.3 Current Pregnancy

The following data elements are collected from the Initial Visit Q – "Current Pregnancy" section. The total number of data fields is 21.

| Data Element | Field Type |
|---|---|
| First day of LMP | Date |
| # of weeks pregnant when you know you are pregnant | Number |
| Do you want to be pregnant? | Select one |
| ○ Wanted to be pregnant<br>○ Wanted to wait until later<br>○ Didn't want to become pregnant at all<br>○ Didn't care | |
| Did you get help from a doctor to be pregnant? | Yes/No |
| Services received to get pregnant | Select one |
| ○ Advice only<br>○ In vitro fertilization<br>○ Artificial insemination<br>○ Medicines or shots to improve your ovulation<br>○ Surgery to correct blocked tubes<br>○ Other type of surgery SPECIFY<br>○ None | |
| Other type surgery spec (If "Other type surgery" checked) | Text |
| Donor egg used? (If "In vitro fertilization" checked) | Yes/No |
| Who donated the egg? | Select one |
| ○ A biologically related relative<br>○ A relative not biologically related to you<br>○ A friend<br>○ An anonymous donor<br>○ Some other person *SPECIFY* | |
| Other donor spec (If "Other donor" checked) | Text |
| In vitro fertilization procedures (If "In vitro fertilization" checked) | Check all that apply |
| ○ No procedures used<br>○ Intracytoplasmic sperm injection (*ICSI*)<br>○ Blastocyst culturing<br>○ Assisted hatching<br>○ Round spermatid nucleic injection (*ROSNI*)<br>○ Cytoplasmic transfer<br>○ Embryo co-culturing<br>○ Pre-Implantation genetic diagnosis (*PGD*)<br>○ Other *SPECIFY* | |
| Other IVF procedures spec (If "Other IVF procedures" checked) | Text |
| Frozen embryo used | Yes/No |
| Sperm source (If "In vitro fertilization" checked) | Select one |
| ○ Husband or partner only<br>○ Donor only<br>○ Both husband or partner and donor | |
| Drugs used to improve ovulation | Check all that apply |

| | |
|---|---|
| ○ Options:<br>○ Clomid / Follistim / Pregnyl / Gonal F / Repronex / Profasi / Bravelle / Pergonal / Novarel / Other drug SPECIFY / None | |
| Other drugs used to improve ovulation spec (If "Other drugs used to improve ovulation" checked) | Text |
| Has vaginal bleeding | Yes/No |
| Frequency of vaginal bleeding (If "Has vaginal bleeding" = Yes) | Select one |
| ○ Options:<br>○ 5 or more times a week / 2-4 times a week / Once a week / 1-3 times a month / Less than once a month | |
| Has nausea | Yes/No |
| Frequency of nausea (If "Has nausea" = Yes) | Select one |
| ○ Options:<br>○ 5 or more times a week / 2-4 times a week / Once a week / 1-3 times a month / Less than once a month | |
| # of days having fever | Number |

## 5.4 Oral Health

The following data elements are collected from the Initial Visit Q – "Oral Health" section.
The total number of data fields is 3.

| **Data Element** | **Field Type** |
|---|---|
| Teeth condition | Select one |
| ○ Options:<br>○ Excellent / Very good / Good / Fair / Poor | |
| Last dental visit | Select one |
| ○ Options:<br>○ Within the past year / Within the past 2 years / Within the past 5 years / 5 or more years ago / Never | |
| # of removed permanent teeth | Select one |
| ○ Options:<br>○ 1 to 5 / 6 or more but not all / All / None | |

## 5.5 Medical History

The following data elements are collected from the Initial Visit Q – "Medical History" section.

**NOTE:**

- **For the medical condition data elements, "Age when first diagnosed" and "Medications/treatment" data elements are also collected.**

The total number of data fields is 29 + 53 x 3 = 188.

| **Data Element** | **Field Type** |
|---|---|
| Abnormal pap smear | Yes/No |
| Has procedures for abnormal pap smear | Yes/No |

| | |
|---|---|
| Procedure type for abnormal pap smear (If "Has procedures for abnormal pap smear" = Yes) | Check all that apply |
| ○ Options:<br>○ Cone / Cryotherapy / Laser / Curettage / Other | |
| Other procedure type for abnormal pap smear spec (If "Other procedure type for abnormal pap smear" checked) | Text |
| Procedure date (If "Has procedures for abnormal pap smear" = Yes) | Date |
| Has uterine fibroids | Yes/No |
| Has myomectomy (If "Has uterine fibroids" = Yes) | Yes/No |
| Myomectomy date (If "Has myomectomy" = Yes) | Date |
| Has hysteroscopic resection (If "Has uterine fibroids" = Yes) | Yes/No |
| Hysteroscopic date (If "Has hysteroscopic resection" = Yes) | Date |
| Has lupron (If "Has uterine fibroids" = Yes) | Yes/No |
| Lupron Date (If "Has lupron" = Yes) | Date |
| Has uterus birth defect | Yes/No |
| Removed uterine septum (If "Has uterus birth defect" = Yes) | Yes/No |
| Uterine septum removal date (If "Removed uterine septum" = Yes) | Date |
| Has blood transfusion | Yes/No |
| Blood transfusion date (If "Has blood transfusion" = Yes; In years) | Year |
| # of units for blood transfusion (If "Has blood transfusion" = Yes) | Number |
| Reason for blood transfusion (If "Has blood transfusion" = Yes) | Text |
| Has diabetes (not pregnant) | Yes/No |
| Has taken insulin (If "Has diabetes (not pregnant)" = Yes) | Yes/No |
| Insulin method (If "Has taken insulin" = Yes) | Check all that apply |
| ○ Diabetes medication by mouth (i.e. pills)<br>○ Insulin, either by injection or by pump | |
| Family member health problem | Check all that apply |
| ○ Birth defects<br>○ Diabetes<br>○ High blood Pressure<br>○ Preterm birth<br>○ Preterm labor<br>○ Baby that was small for gestational age (IUGR)<br>○ Stillbirth<br>○ Developmental delays<br>○ Mental retardation<br>○ Other SPECIFY | |
| Family member other health problem spec (If "Family member other health problem" checked) | Text |
| Born premature | Yes/No |
| # of weeks pregnant was your mother when you were born? | Number |
| Birth weight (By pounds) | Number |
| Birth defects | Yes/No |
| Birth defect spec (If "Birth defects" = Yes) | Text |
| **For the following medical conditions, "Age when first diagnosed" and "Medications/treatment" data elements are also collected.** | |

| | |
|---|---|
| Has asthma | Yes/No |
| Has Eczema or atopic dermatitis | Yes/No |
| Has hay fever or seasonal allergies | Yes/No |
| Has peanuts allergy | Yes/No |
| Has bee stings allergy | Yes/No |
| Has shellfish allergy | Yes/No |
| Has cats allergy | Yes/No |
| Has dogs allergy | Yes/No |
| Has other allergies | Yes/No |
| Other allergies spec (If "Has other allergies" = Yes) | Text |
| Has antiphospholipid antibody syndrome | Yes/No |
| Has lupus | Yes/No |
| Has rheumatoid arthritis | Yes/No |
| Has Hyperthyroidism (overactive) | Yes/No |
| Has Hypothyroidism (underactive) | Yes/No |
| Has Other endocrine disorder | Yes/No |
| Other endocrine disorder spec (If "Has Other endocrine disorder" = Yes) | Text |
| Has Inflammatory bowel disease | Yes/No |
| Has Other autoimmune disease | Yes/No |
| Other autoimmune disease spec (If "Other autoimmune disease" = Yes) | Text |
| Has Sickle cell disease | Yes/No |
| Has Thrombophilia | Yes/No |
| Has Other blood disorder | Yes/No |
| Other blood disorder spec (If "Other blood disorder" = Yes) | Text |
| Has Heart disease | Yes/No |
| Has Hypertension or high blood pressure when you're not pregnant | Yes/No |
| Has Other gastrointestinal disease | Yes/No |
| Other gastrointestinal disease spec (If "Other gastrointestinal disease " = Yes) | Text |
| Has Kidney disease | Yes/No |
| Has Kidney stones | Yes/No |
| Has Hepatitis | Yes/No |
| Has Ovarian cysts or polycystic ovarian syndrome (PCOS) | Yes/No |
| Has HIV | Yes/No |
| Has Malaria | Yes/No |
| Has Tuberculosis | Yes/No |
| Has Other infections | Yes/No |
| Other infections spec (If "Other infections" = Yes) | Text |
| Has Cancer | Yes/No |
| Cancer spec (If "Cancer" = Yes) | Text |
| Has Epilepsy or seizures | Yes/No |

| | |
|---|---|
| Has Sleep apnea | Yes/No |
| Has Bipolar disorder | Yes/No |
| Has Migraines | Yes/No |
| Has Other neurological disorders | Yes/No |
| Other neurological disorders spec (If "Other neurological disorders" = Yes) | Text |
| Has Depression other than bipolar disorder | Yes/No |
| Has Anxiety disorder | Yes/No |
| Has Anorexia nervosa | Yes/No |
| Has Bulimia | Yes/No |
| Has Other mental illnesses | Yes/No |
| Other mental illnesses spec (If "Other mental illnesses" = Yes) | Text |
| Has Other chronic conditions | Yes/No |
| Other chronic conditions spec (If "Other chronic conditions" = Yes) | Text |

## 5.6 Medication

The following data elements are collected from the Initial Visit Q – "Medication, Vitamins, and Supplements" section.

**NOTE:**

- **For the following medications, "Method", "Dose", "Frequency", and "Duration" data elements are also collected.**
- **The following medications data elements (including method, dose, frequency, and duration) are collected 3 times: Initial Q (3 months before pregnant), Initial Q (Now), and Second Trimester Q (Now).**

The total number of data fields is 65 x 4 x 3 = 780.

| **Data Element** | **Field Type** |
|---|---|
| Taken Tylenol (Acetaminophen, Datril) | Yes/No |
| Taken Ibuprofen (Motrin, Advil) | Yes/No |
| Taken Aleve (Naproxen) | Yes/No |
| Taken Aspirin | Yes/No |
| Taken other pain medication | Yes/No |
| Other pain medication spec (If "Taken other pain medication" = Yes) | Text |
| Taken Benadryl | Yes/No |
| Taken Cough medicine/syrup | Yes/No |
| Taken Allergy medicine (Claritin, Allegra, Zyrtec, Flonase) | Yes/No |
| Taken Sudafed | Yes/No |
| Taken Albuterol inhaler | Yes/No |
| Taken Asthma medicine (Singulair, Azmacort, Pulmicort, Aerobid, Flovent) | Yes/No |
| Taken other allergy medication | Yes/No |

| | |
|---|---|
| Other allergy medication spec (If "Taken other allergy medication" = Yes) | Text |
| Taken Prozac | Yes/No |
| Taken Wellbutrin (Zyban) | Yes/No |
| Taken Paxil | Yes/No |
| Taken Zoloft | Yes/No |
| Taken Effexor (Venlafaxine) | Yes/No |
| Taken Celexa | Yes/No |
| Taken other anxiety medication | Yes/No |
| Other anxiety medication spec (If "Taken other anxiety medication" = Yes) | Text |
| Taken Dilantin (Phenytoin) | Yes/No |
| Taken Valproic acid (Depakene) | Yes/No |
| Taken Carbamazepine (Tegretol) | Yes/No |
| Taken other anti-seizure medication | Yes/No |
| Other anti-seizure medication spec (If "Taken other anti-seizure medication" = Yes) | Text |
| Taken Heparin | Yes/No |
| Taken Coumadin (warfarin) | Yes/No |
| Taken Hydrochlorothiazide | Yes/No |
| Taken Beta blocker (Atenolol) | Yes/No |
| Taken Verapamil | Yes/No |
| Taken ACE inhibitor | Yes/No |
| Taken other blood pressure medication | Yes/No |
| Other blood pressure medication spec (If "Taken other blood pressure medication" = Yes) | Text |
| Taken Insulin | Yes/No |
| Taken Metformin | Yes/No |
| Taken Glyburide | Yes/No |
| Taken other diabetes medication | Yes/No |
| Other diabetes medication spec (If "Taken other diabetes medication" = Yes) | Yes/No |
| Taken Amoxicillin | Yes/No |
| Taken Ampicillin | Yes/No |
| Taken Augmentin | Yes/No |
| Taken Bactrim | Yes/No |
| Taken Ciprofloxacin | Yes/No |
| Taken Doxycycline | Yes/No |
| Taken Erythromycin | Yes/No |
| Taken Levofloxacin | Yes/No |
| Taken Penicillin | Yes/No |
| Taken Septra | Yes/No |
| Taken Zithromax | Yes/No |
| Taken other antibiotics | Yes/No |
| Other antibiotics spec (If "Taken other antibiotics" = Yes) | Text |
| Taken Accutane or Retin-A | Yes/No |
| Taken Misoprostol | Yes/No |

| | |
|---|---|
| Taken Nicotine patch or gum | Yes/No |
| Taken Nicotine | Yes/No |
| Taken Weight loss medications | Yes/No |
| Weight loss medications spec (If "Weight loss medications" = Yes) | Text |
| Taken other medication | Yes/No |
| Other medication spec (If "Taken other medication" = "Yes") | Text |
| Taken herbal supplements | Yes/No |
| Herbal supplements spec (If "Taken herbal supplements" = Yes) | Text |
| Taken vitamin supplements | Select one |
| ○ Options:<br>○ Prenatal Vitamin / Multivitamin / Folic Acid / Iron / Calcium / Vitamin C / Zinc / Fish oil SPECIFY / Other SPECIFY / None | |
| Vitamin supplements spec (If "Taken vitamin supplements" = "Other") | Text |
| Fish oil spec (If "Taken vitamin supplements" = "Fish oil") | Text |

## 5.7 Emotional Health

The following data elements are collected from the Initial Visit Q – "Emotional health" section.

**NOTE:**

- **The following emotional health data elements are collected 2 times: Initial Q, Second Trimester Q.**

The total number of data fields is 31 x 2 = 62.

| **Data Element** | **Field Type** |
|---|---|
| **The following data elements collect "Over the last 2 weeks, how often have you been bothered by ___" with a scale of "Not at all; Several days; More than half the days; Nearly every day".**<br>**Subtotal data elements: 9** | |
| ✓ little interest or pleasure in doing things<br>✓ feeling down, depressed, or hopeless<br>✓ trouble falling or staying asleep, or sleeping too much<br>✓ feeling tired or having little energy<br>✓ a poor appetite or overeating<br>✓ feeling bad about yourself or that you are a failure or have let yourself or your family down<br>✓ trouble concentrating on things, such as reading the newspaper or watching TV<br>✓ moving or speaking so slowly that other people could have noticed or opposite - being so fidgety or restless that you have been moving around a lot more than usual<br>✓ thoughts that you would be better off dead or of hurting yourself in some way | |
| In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic? | Yes/No |
| Has this anxiety attack ever happened before? (If "anxiety attack" question = Yes) | Yes/No |

| | |
|---|---|
| Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable? (If "anxiety attack" question = Yes) | Yes/No |
| Do these attacks bother you a lot or are you worried about having another attack? (If "anxiety attack" question = Yes) | Yes/No |
| During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? (If "anxiety attack" question = Yes) | Yes/No |
| How difficult have these anxiety problems made it for you to do your work, take care of things at home, or get along with other people? (If "anxiety attack" question = Yes) | Select one |
| ○ Options:<br>○ Not difficult at all / Somewhat difficult / Very difficult / Extremely difficult | |
| **The following data elements collect "To what extent is/are _____ currently a stress or hassle for you?" with a scale of "No stress; Some stress; Moderate stress; Severe stress".<br>Subtotal data elements: 11** | |
| ✓ Financial worries (like food, shelter, healthcare, transportation)<br>✓ Money worries (like bills)<br>✓ Problems related to family<br>✓ That have to move, either recently or in the future<br>✓ The recent loss of a loved one<br>✓ The current pregnancy<br>✓ Current abuse (sexual, emotional, or physical)<br>✓ Problems with alcohol and/or drugs<br>✓ Work problems (such as being laid off)<br>✓ Problems related to friends<br>✓ Feeling generally "overloaded" | |
| Have you experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior because of your gender, sexual orientation, race, color or ethnicity, socioeconomic position or social class, religion, or a disability in any of the following situations: | Check all that apply |
| ○ At school<br>○ Getting housing<br>○ Getting a job<br>○ Getting service in a store or restaurant<br>○ Getting credit, bank loans, or a mortgage<br>○ On the street or in a public setting<br>○ At work<br>○ Getting medical care<br>○ From the police or in the court<br>○ Other SPECIFY<br>○ None | |
| How often has this discrimination happened? | Select one |

| |
|---|
| ○ Options:<br>○ Often / Fairly often / Seldom |
| **The following data elements are collected with a scale of 1 to 5. 1 stands for "Does not describe me at all," and 5 stands for "Describes me very well."**<br>**Subtotal data elements: 4** |
| ✓ I look for creative ways to alter difficult situations.<br>✓ Regardless of what happens to me, I believe I can control my reaction to it.<br>✓ I believe I can grow in positive ways by dealing with difficult situations.<br>✓ I actively look for ways to replace the losses I encounter in life. |

## 5.8 Health Behaviors

The following data elements are collected from the Initial Visit Q – "Health Behaviors" section.

**NOTE:**

- **The following health behavior data elements are collected 2 times: Initial Q, Second Trimester Q.**

The total number of data fields is 7 x 2 = 14.

| Data Element | Field Type |
|---|---|
| During the past 7 days, on a typical day, how much time did you sleep at night? (hours) | Number |
| During the past 7 days, on a typical day, how much time did you sleep during the day? (hours) | Number |
| **The following data elements collect data with a scale of "0 days; 1 day; 2 days; 3 days; 4 days; 5 days; 6 days; 7 days".**<br>**Subtotal data elements: 5** | |
| ✓ In the 3 months before you became pregnant, how many days of the week did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activity? | |
| ✓ In the 3 months before you became pregnant, how many days of the week did you do physical activity for at least 30 minutes that did not make you sweat and breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors? | |
| ✓ During your current pregnancy, on how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard, such as basketball, soccer, running, swimming laps, fast bicycling, fast dancing, or similar aerobic activity? | |
| ✓ During your current pregnancy, on how many of the past 7 days did you do physical activity for at least 30 minutes that did not make you sweat and breathe hard, such as fast walking, slow bicycling, skating, pushing a lawn mower, or mopping floors? | |
| ✓ In the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? | |

## 5.9 Tobacco Products/Alcohol

The following data elements are collected from the Initial Visit Q – "Tobacco Products/Alcohol" section.

**NOTE:**

- **The following tobacco products/alcohol data elements are collected 3 times: Initial Q (3 months before pregnant), Initial Q (Now), and Second Trimester Q (Now).**

The total number of data fields is 1 + 14 x 3 = 43.

| Data Element | Field Type |
|---|---|
| Have you smoked at least 100 cigarettes in your entire life? | Yes/No |
| **The following data elements are only collected if "Have you smoked at least 100 cigarettes in your entire life" = "Yes". The following data elements are collected 3 times: Initial Q (3 months before pregnant), Initial Q (Now), and Second Trimester Q (Now).** | |
| How many cigarettes did you smoke on an average day? | Select one |
| ○ Options:<br>○ 41 or more cigarettes / 20-40 cigarettes / 11-20 cigarettes / 6-10 cigarettes / 1-5 cigarettes / Less than 1 cigarette / None | |
| How many times a day do you smoke or use tobacco products? | Number |
| When did you stop smoking cigarettes? | Select one |
| ○ More than 2 weeks before you knew you were pregnant<br>○ Less than 2 weeks before you knew you were pregnant<br>○ When you found out you were pregnant<br>○ After you found out you were pregnant<br>○ I never smoked | |
| Did you use any of the following tobacco products? | Check all that apply |
| ○ Pipes<br>○ Cigars<br>○ Nicotine patches or gum<br>○ Snuff<br>○ None<br>○ Other nicotine product SPECIFY<br>○ I have never used tobacco products | |
| Other tobacco products spec (If "Tobacco products" = "Other") | Text |
| How many tobacco products did you use/smoke per day? | Number |
| When did you stop using other tobacco products? | Select one |
| ○ More than 2 weeks before you knew you were pregnant<br>○ Less than 2 weeks before you knew you were pregnant<br>○ When you found out you were pregnant<br>○ After you found out you were pregnant | |
| How many hours per day do people smoke in the same room as you or near enough that you can see or smell the smoke? | Number |
| How often did you drink alcoholic beverages including wine, beer, drinks containing hard liquor, wine coolers, hard lemonade, or hard cider? | Select one |

| | |
|---|---|
| ○ Options:<br>○ 5 or more times a week / 2 to 4 times a week / Once a week / 1 to 3 times a month / Less than once a month / I did not drink alcoholic beverages the 3 months before I knew I was pregnant / I never drink alcohol | |
| How often did you have 5 or more drinks within a couple of hours? | Select one |
| ○ Options:<br>○ About once a month / About once a week / About once a day / Never | |
| What types of alcoholic beverages did you drink? | Check all that apply |
| ○ Wine<br>○ Beer<br>○ Hard liquor/mixed drinks<br>○ Wine coolers<br>○ Hard lemonade/hard cider<br>○ Other alcoholic beverage *SPECIFY* | |
| Other type of beverages spec (If "What types of alcoholic beverages" = "Other") | Text |
| When did you stop drinking alcoholic beverages? | Select one |
| ○ More than 2 weeks before you knew you were pregnant<br>○ Less than 2 weeks before you knew you were pregnant<br>○ When you found out you were pregnant<br>○ After you found out you were pregnant | |
| Did you use any of the following drugs on your own without a doctor's prescription? | Check all that apply |
| ○ Sedatives, including either barbituates or sleeping pills on your own (*i.e. Amytal, Seconal, or Halcion*)<br>○ Tranquilizers or "nerve pills" (*for example, Librium, Valium, Ativan, or Xanax*)<br>○ Marijuana or hashish<br>○ Analgesics or other prescription painkillers (*Do NOT include normal use of aspirin or Tylenol without codeine but DO include use of Tylenol with codeine, Percocet, Lortab, Codeine, OxyContin, oxycodone, morphine, methadone, or other prescription painkillers*)<br>○ Inhalants that you sniff or breathe to get high or to feel good (*i.e. Amylnitrate, Nitrous Oxide, or "Whippets," glue, or spray paint*)<br>○ Cocaine, crack, or free base<br>○ LSD or other hallucinogens (*i.e. PCP, angel dust, peyote, ecstasy, or mescaline*)<br>○ Stimulants (*i.e. amphetamine, methamphetamine*)<br>○ None | |

## 5.10 Diet History

The following data elements are collected from the Initial Visit Q – "Diet History" section.

**NOTE:**

- **The following diet history data elements are collected 2 times: Initial Q and Second Trimester Q.**

The total number of data fields is 1 + 22 x 2 = 45.

| Data Element | Field Type |
|---|---|
| During the 3 months before you became pregnant, how many of the following types of caffeinated beverages did you drink per day on average? Caffeinated coffee, Caffeinated tea, Soda with Caffeine (e.g. Coke, Pepsi, Dr. Pepper, Mountain Dew), Energy drinks (e.g. Red Bull, Amp) | Select one |
| ○ Options:<br>○ Less than one per day / 1 per day / 2 per day / 3 per day / 4 per day / 5 per day / 6 per day / 7 per day / 8 per day / 9 per day/ 10 per day / 10+ per day / None | |
| How many of these caffeinated beverages do you drink per day NOW? Caffeinated coffee, Caffeinated tea,<br>Soda with Caffeine (e.g. Coke, Pepsi, Dr. Pepper, Mountain Dew),<br>Energy drinks (e.g. Red Bull, Amp) | Select one |
| ○ Options:<br>○ Less than one per day / 1 per day / 2 per day / 3 per day / 4 per day / 5 per day / 6 per day / 7 per day / 8 per day / 9 per day/ 10 per day / 10+ per day / None | |
| During the past month, when you ate cereal, which kinds did you usually eat? | Check all that apply |
| ○ Cooked cereals (such as oatmeal, cream of wheat, grits)<br>○ All bran cereals (such as All Bran, Fiber One, 100% Bran, or Bran Buds)<br>○ Cereals with some bran or fiber (such as Cheerios, Raisin Bran, Shredded Wheat, Total, Wheaties, 40% Bran flakes, Granola, Grape Nuts, Muselix, etc.)<br>○ Cereals with little bran or fiber (such as Corn Flakes, Honey Nut Cheerios, Froot Loops, Rice Krispies, Kix, Frosted Flakes, Special K, Cap'n Crunch, Blueberry Morning, Product 19, etc.)<br>○ Other | |
| **The following data elements collect the diet behavior for the past 30 days with a scale of "Never, 1-3 times last month; 1-2 times per week; 3-4 times per week; 5-6 times per week; 1 time per day; 2 times per day; 3 times per day; 4 times per day; 5 or more times per day". Subtotal data elements: 18** | |
| ✓ HOT OR COLD CEREALS | |
| ✓ MILK, either to drink or on cereal | |
| ✓ regular, carbonated SODA OR SOFT DRINKS that contain sugar | |
| ✓ 100% FRUIT JUICE, such as orange, mango, apple, and grape juices | |
| ✓ FRUIT-FLAVORED DRINKS with sugar (such as Kool-Aid, Hi-C, lemonade, or cranberry cocktail) | |
| ✓ fresh, frozen, or canned fruit | |
| ✓ a green leafy or lettuce SALAD, with or without other vegetables | |
| ✓ FRENCH FRIES, home fries, or hash brown potatoes | |
| ✓ WHITE POTATOES | |
| ✓ COOKED DRIED BEANS, such as refried beans, baked beans, bean soup, and pork and beans | |
| ✓ OTHER VEGETABLES | |
| ✓ TOMATO SAUCES such as spaghetti sauce or pizza with tomato sauce | |
| ✓ SALSA | |
| ✓ RED MEAT | |
| ✓ WHOLE GRAIN BREAD including toast, rolls and in sandwiches | |
| ✓ DOUGHNUTS, sweet rolls, Danish, muffins, or pop-tarts | |

| |
|---|
| ✓ COOKIES, CAKE, PIE, or BROWNIES |
| ✓ CHEESE |
| **The following data elements collect the amount specified during the past year with a scale of "Never; 1-3 per month; 1 per week; 2-4 per week; 5-6 per week; 1 per day; 2-3 per day; 4-5 per day; 6+ per day".**<br>**Subtotal data elements: 4** |
| ✓ Canned tuna fish (3-4 oz.). |
| ✓ Shrimp, lobster, scallops as a main dish |
| ✓ Dark meat fish, e.g. mackerel, salmon, sardines, bluefish, swordfish (3-5 oz.). |
| ✓ Other fish, e.g. cod, haddock, halibut (3-5 oz.). |

## 5.11 Environmental Exposure

The following data elements are collected from the Initial Visit Q – "More About You" section.

**NOTE:**

- **The following environmental exposure data elements are collected 3 times: Initial Q, Second Trimester Q, and Postpartum Q.**

The total number of data fields is 64 x 3 = 192.

| **Data Element** | **Field Type** |
|---|---|
| Which of the following best describes your home? | Select one |
| o House<br>o House split into 2 apartments/flats<br>o Building with 3 or more apartments/flats<br>o Hotel/Motel<br>o Migrant Camp<br>o Trailer or mobile home<br>o Other *SPECIFY* | |
| Other description of home spec (If "Which of the following best describes your home" = "Other") | Text |
| Total number of rooms in your home | Number |
| Total number of people that live in your home | Number |
| Do you have electricity in your home? | Yes/No |
| What material is the majority of the floor or floor covering of your home made of? | Select one |
| o Carpet/rug<br>o Wood<br>o Cement or Firme<br>o Tile<br>o Soil<br>o Other *SPECIFY* | |
| Other material spec (If "What material is the majority of the floor or floor covering of your home made of?" = "Other") | Text |
| What is your roof made of? | Select one |
| o Asphalt Shingles | |

| | |
|---|---|
| ○ Tile<br>○ Concrete<br>○ Wood<br>○ Aluminum<br>○ Natural Resources (*e.g. straw*)<br>○ Scavenged Resources (*e.g. cardboard*)<br>○ Other *SPECIFY* | |
| Other roof spec (If "What is your roof made of?" = "Other") | Text |
| Does the roof of your house leak? | Yes/No |
| What type of sanitary service does your home have? | Select one |
| ○ Toilet with a water connection<br>○ Toilet without a water connection<br>○ Outhouse<br>○ No sanitary service | |
| Do you have a stove/oven in your home? | Yes/No |
| What do you usually use to heat the stove/oven in your home? (If "Do you have a stove/oven in your home?" = Yes) | Select one |
| ○ Gas<br>○ Electricity<br>○ Wood<br>○ Charcoal<br>○ Kerosene<br>○ Crop waste e.g. compost<br>○ Oil<br>○ Other *SPECIFY* | |
| Other heating materials spec (If "What do you usually use to heat the stove/oven in your home?" = "Other") | Text |
| Do you sleep in the same room you cook in? | Yes/No |
| Do you heat your home? | Yes/No |
| What fuel do you usually use to heat your home? (If "Do you heat your home?" = Yes) | Select one |
| ○ Gas<br>○ Electricity<br>○ Wood<br>○ Charcoal<br>○ Kerosene<br>○ Crop waste e.g. compost<br>○ Oil<br>○ Other *SPECIFY* | |
| Other heating materials spec (If "What fuel do you usually use to heat your home?" = "Other") | Text |
| Does your kitchen get smoky when you cook or heat it? | Select one |
| ○ Options:<br>○ Not smoky / A little smoky / Pretty smoky / Very smoky (eyes and/or breathing affected) | |
| Do you get water from a tap in or around your home? | Yes/No |
| What is your source of drinking water? (If "Do you get water from a tap in or around your home?" = No) | Select one |
| ○ Communal tap away from your home | |

| | |
|---|---|
| ○ Bottled water<br>○ Rain collection<br>○ River<br>○ Pond<br>○ Well | |
| Do you boil your water before drinking it? | Yes/No |
| How often do you or someone else usually sweep, mop, or vacuum your home? | Select one |
| ○ Options:<br>○ Never / Less than once a month / 1-3 times a month / 1-3 times a week / 4-6 times a week / Daily / Once a week | |
| Since you became pregnant, have you ever seen any mould or mildew on walls or other surfaces (other than food) inside your home? | Yes/No |
| Since you became pregnant, have you ever seen any water damage in your home, this could be from broken pipes, a leaky roof or floods? | Yes/No |
| Have you seen, or have you been aware of any of the following inside your home | Check all that apply |
| ○ Options:<br>○ Mice or Rats / Cockroaches / NONE | |
| How many cats and dogs do you have at home? | Number |
| Since you became pregnant, have pesticides been applied in your home? | Yes/No |
| Since you became pregnant, have pesticides been applied outside your home? | Yes/No |
| Since you became pregnant, have pesticides been applied on your pets? | Yes/No |
| Have you personally applied any of these pesticides? | Yes/No |
| Has anyone living with you worked on a farm or in a green house? | Yes/No |
| How often does the air in the area where you live make it difficult to breathe? | Select one |
| ○ Options:<br>○ Never / Sometimes / Frequently / Always | |
| How often does the air in the area where you live make your eyes sting? | Select one |
| ○ Options:<br>○ Never / Sometimes / Frequently / Always | |
| Do you live within 5 minutes' walk of an agricultural field? | Yes/No |
| Do you live within 5 minutes' walk of a road that is used by large trucks? | Yes/No |
| Do you live within 5 minutes' walk of a site where chemicals are known to be dumped? | Yes/No |
| Do you live within 5 minutes' walk of a factory that emits fumes or smoke? | Yes/No |
| **The following data elements collect "within 5 minutes' walking distance of home ___" with a scale of "Not a problem, Some problem, A big problem."**<br>**Subtotal data elements: 8** | |
| ✓ Loud music or other noise (constructions, trains, etc.)<br>✓ Rubbish/Trash and litter on the streets<br>✓ People using or selling drugs<br>✓ Crime, such as robberies or assaults | |

| | |
|---|---|
| ✓ No safe place for children to play<br>✓ Not safe to walk alone at night<br>✓ Stray dogs<br>✓ Dogs barking at night | |
| Since you became pregnant, have you worked formally inside or outside of your home? | Yes/No |
| How many hours per week have you worked | Number |
| Does/Did this include the evening or night shift (starting after 2 PM)? | Yes/No |
| Do/Did you rotate among different shifts for this job? | Yes/No |
| In what position have you spent most of your working day? | Select one |
| o Options:<br>o Sitting / Standing / Walking / Other | |
| Since becoming pregnant, have you worked in any of these businesses or industries? | Check all that apply |
| o Janitor or house cleaning<br>o Hair salon<br>o Nail salon<br>o Dry cleaning<br>o Car or truck repair<br>o Gas station<br>o Construction<br>o Healthcare or dentistry<br>o Science laboratory<br>o Farm or plant nursery<br>o Landscaping or grounds keeping<br>o Printing company<br>o Chemical plant<br>o Hazardous waste<br>o Plastic products or manufacturing<br>o Semiconductor manufacturing<br>o Electronics manufacturing<br>o Other manufacturing *SPECIFY* | |
| Other manufacturing spec (If "Since becoming pregnant, have you worked in any of these businesses or industries?" = "Other manufacturing") | Text |
| Since becoming pregnant, have you done any of these activities in your work? | Check all that apply |
| o Use dyes (*hair or textile*)<br>o Strip or thin paint<br>o Use dry cleaning chemicals<br>o Make or spray fungicides (*chemicals which kill molds*)<br>o Use solvents or degreasers (*for cleaning sticky/greasy things*)<br>o Make or spray pesticides (*chemicals which kill insects*)<br>o Weld<br>o Apply glues or adhesives<br>o Apply artificial nails<br>o Mix or apply paints or lacquers<br>o Degrease tools, machines or electronics<br>o Handle or make pharmaceuticals | |

| | |
|---|---|
| ○ Apply varnish, finish or seals<br>○ Use strong acids or bases<br>○ Use lead or other metals<br>○ Plastic products or manufacturing<br>○ Use X-ray or radioactive substances<br>○ Work with anesthetic gases or sterilizers<br>○ Make or spray herbicides (*chemicals which kill weeds*)<br>○ Work with laboratory chemicals<br>○ Use janitorial/cleaning chemicals<br>○ Use other chemicals *SPECIFY* | |
| Other chemicals spec (If "Since becoming pregnant, have you done any of these activities in your work?" = "Other chemicals") | Text |
| **The following data elements collect "Rank the following for this working environment" with a scale of "Not a problem, Some problem, A big problem".**<br>**Subtotal data elements: 9** | |
| ✓ Very cold (less than 60F/15C)<br>✓ Very hot (greater than 80F/27C)<br>✓ Loud (can't hear neighbors speak)<br>✓ Dusty, such as from drilling or grinding<br>✓ Smelling strongly from plastic or resin fumes<br>✓ Smelling strongly from lead or other metal fumes<br>✓ Smelling strongly from solvents<br>✓ Poorly ventilated<br>✓ Chronically water damaged or moldy | |
| Since becoming pregnant, has this working environment given you any of the following symptoms? | Check all that apply |
| ○ Headache<br>○ Itchy or teary eyes<br>○ Sneezing or bloody nose<br>○ Coughing or sore throat<br>○ Hives, rash, or itchy skin<br>○ Dizziness<br>○ Nausea<br>○ Vomiting | |

## 5.12 Prenatal Care

The following data elements are collected from the Postpartum Q – "Prenatal Care" section. The total number of data fields is 26.

| Data Element | Field Type |
|---|---|
| Did you get prenatal care as early in your pregnancy as you wanted? | Yes/No |
| During your most recent pregnancy, have you had any of the following problems when you get prenatal care? | Check all that apply |
| ○ I couldn't get an appointment when I wanted one<br>○ I didn't have enough money or insurance to pay for my visits<br>○ I had no way to get to the clinic or doctor's office<br>○ I couldn't take time off from work | |

| | |
|---|---|
| ○ The doctor or my health plan would not start care as early as I wanted<br>○ I didn't have my Medicaid card<br>○ I had no one to take care of my children<br>○ I had too many other things going on<br>○ I didn't want anyone to know I was pregnant<br>○ Other SPECIFY | |
| Other reason spec (If "During your most recent pregnancy, have you had any of the following problems when you get prenatal care?" = "Other") | Text |
| How was your prenatal care paid for? | Check all that apply |
| ○ Medicaid<br>○ Personal income (*cash, check, or credit card*)<br>○ Health insurance or HMO (*including insurance from your work or your husband's work*)<br>○ State Specific<br>○ Basic Health Plan<br>○ Other SPECIFY<br>○ None | |
| Other payment spec (If "How was your prenatal care paid for?" = "Other") | Text |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the following things? | Check all that apply |
| ○ How smoking during pregnancy could affect your baby<br>○ Breastfeeding your baby<br>○ How drinking alcohol during pregnancy could affect your baby<br>○ Using a seat belt during your pregnancy<br>○ Medicines that are safe to take during your pregnancy<br>○ How using illegal drugs could affect your baby<br>○ Doing tests to screen for birth defects or diseases that run in your family<br>○ What to do if your labor starts early<br>○ How eating fish containing high levels of mercury could affect your baby<br>○ How much weight you should gain during your pregnancy<br>○ About "Baby blues" or postpartum depression<br>○ Taking a multivitamin or a prenatal vitamin during your pregnancy<br>○ None of above | |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the following questions? | Check all that apply |
| ○ How much alcohol you were drinking<br>○ If you planned to use birth control after your baby was born<br>○ If someone was hurting you emotionally or physically<br>○ If you were using illegal drugs (*marijuana or hash, cocaine, crack, etc.)*<br>○ If you wanted to be tested for HIV (*the virus that causes AIDS*)<br>○ None of above | |
| During your prenatal care visits, were you satisfied with any of the following? | Check all that apply |
| ○ The amount of time you had to wait after you arrived for your visits<br>○ The amount of time the doctor or nurse spent with you during your visits<br>○ The advice you got on how to take care of yourself<br>○ The understanding and respect that the staff showed toward you as a person<br>○ None of above | |

| | |
|---|---|
| At any time during your most recent pregnancy, did your regular prenatal care provider ask you to see a specialist doctor for help with any health problem(s)? | Yes/No |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about getting your blood tested for the disease called toxoplasmosis? | Yes/No |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the following things? | Check all that apply |
| ○ Not touching your mouth or eyes while handling raw meat<br>○ Cooking meat to "well done"<br>○ Washing hands and utensils after handling raw meat<br>○ Washing hands after contact with soil, sand, litter, or any other materials that may be contaminated with cat feces<br>○ Not feeding cats raw or undercooked meat<br>○ Not drinking/eating unpasteurized dairy products<br>○ None of above | |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about the bacteria Group B Strep (Beta Strep) that mothers can pass to their newborns during birth? | Yes/No |
| At any time during your most recent pregnancy, did you get tested for the bacteria Group B Strep (Beta Strep)? | Yes/No |
| At any time during your most recent pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)? | Yes/No |
| When was your most recent HIV test during this pregnancy? | Select one |
| ○ During the first 3 months of pregnancy<br>○ During the second 3 months of pregnancy<br>○ During the last 3 months of pregnancy<br>○ Unsure when, but during pregnancy and before delivery<br>○ At labor and delivery<br>○ After delivery but before hospital discharge | |
| Were you offered an HIV test during your most recent pregnancy or delivery? | Yes/No |
| Did you turn down the HIV test? | Yes/No |
| Why did you turn down the HIV test? (If "Did you turn down the HIV test?" = Yes) | Check all that apply |
| ○ I did not think I was at risk for HIV<br>○ I did not want people to think I was at risk for HIV<br>○ I was afraid of getting the result<br>○ I was tested before this pregnancy, and did not think I needed to be tested again<br>○ Other *SPECIFY* | |
| Other reason spec (If "Why did you turn down the HIV test?" = "Other") | Text |
| Had you been tested for HIV before this pregnancy? | Yes/No |
| When were you tested before this pregnancy? (If "Had you been tested for HIV before this pregnancy?" = Yes) | Select one |
| ○ Less than 6 months before you got pregnant<br>○ 6 months to 1 year before you got pregnant<br>○ More than 1 year before you got pregnant | |

| | |
|---|---|
| At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker offer you a flu vaccination or tell you to get one? | Yes/No |
| Did you get a flu vaccination during your most recent pregnancy? | Yes/No |
| What were your reasons for not getting a flu vaccination during your most recent pregnancy? (If "Did you get a flu vaccination during your most recent pregnancy?" = No) | Check all that apply |
| ○ My doctor didn't mention anything about a flu vaccination during my pregnancy<br>○ I was worried about side effects of the flu vaccination for me<br>○ I was worried that the flu vaccination might harm my baby<br>○ I wasn't pregnant during the flu season (*November–February*)<br>○ I was in my first trimester during the flu season (*November–February*)<br>○ I don't normally get a flu vaccination<br>○ Other *SPECIFY* | |
| Other reason spec (If "What were your reasons for not getting a flu vaccination during your most recent pregnancy?" = "Other") | Text |
| Have you ever had a flu vaccination when you were not pregnant? | Yes/No |

## 5.13 Most Recent Pregnancy

The following data elements are collected from the Postpartum Q – "Most Recent Pregnancy" section.

The total number of data fields is 11.

| **Data Element** | **Field Type** |
|---|---|
| Pregnancy problems | Check all that apply |
| ○ I was hurt in a car accident<br>○ Severe nausea, vomiting, or dehydration<br>○ Problems with the placenta (*i.e. abruption placentae or placenta previa*)<br>○ High blood pressure, hypertension (*including pregnancy-induced hypertension [PIH], preeclampsia, or toxemia*)<br>○ Vaginal bleeding<br>○ Cervix had to be sewn shut (*incompetent cervix*)<br>○ Labor pains more than 3 weeks before my baby was due (*preterm or early labor*)<br>○ Water broke more than 3 weeks before my baby was due (*premature rupture of membranes [PROM]*)<br>○ Kidney or bladder (*urinary tract*) infection<br>○ I had to have a blood transfusion<br>○ High blood sugar (*diabetes*) that started during this pregnancy<br>○ None | |
| Did you do any of the following things because of these problems? | Check all that apply |
| ○ I went to the hospital or emergency room and stayed less than 1 day<br>○ I stayed in bed at home more than 2 days because of my doctor's or nurse's advice<br>○ I went to the hospital and stayed 1 to 7 days<br>○ I went to the hospital and stayed more than 7 days<br>○ None | |

| | |
|---|---|
| At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker tell you to stay in bed for at least 1 week? | Yes/No |
| How many weeks pregnant were you when you were told to stay in bed? (If "Told to stay in bed for at least 1 week" = Yes) | Number |
| How often were you able to follow your provider's instruction to stay in bed? | Check all that apply |
| ○ Options:<br>○ Always / Often / Sometimes / Rarely / Never | |
| What types of support would have helped you to stay in bed for the recommended time? | Check all that apply |
| ○ Help with child care<br>○ Money to make up for not working<br>○ Help with housework<br>○ Knowing I wouldn't lose my job<br>○ Other SPECIFY<br>○ None | |
| Other types of support (If "What types of support would have helped you to stay in bed for the recommended time?" = "Other") | Text |
| During the last 3 months before your new baby was born, did you have any of the following? | Check all that apply |
| ○ I was in a physical fight<br>○ A close family member was very sick and had to go to the hospital<br>○ I was homeless<br>○ I argued with my husband or partner more than usual<br>○ I got separated or divorced from my husband or partner<br>○ Someone very close to me died<br>○ My husband or partner or I went to jail<br>○ I moved to a new address<br>○ My husband or partner said he didn't want me to be pregnant<br>○ My husband or partner lost his job<br>○ Someone very close to me had a bad problem with drinking or drugs<br>○ I had a lot of bills I couldn't pay<br>○ I lost my job even though I wanted to go on working<br>○ None | |
| During the last 3 months of your most recent pregnancy, were you physically hurt in any way by your husband or partner? | Yes/No |
| How would you describe the time during your most recent pregnancy? | Select one |
| ○ One of the happiest times of my life<br>○ A happy time with few problems<br>○ A moderately hard time<br>○ A very hard time<br>○ One of the worst times of my life<br>○ Other SPECIFY | |
| Other description spec (If "How would you describe the time during your most recent pregnancy?" = "Other") | Text |

## 5.14 Labor and Delivery

The following data elements are collected from the Postpartum Q – "Labor and Delivery" section.
The total number of data fields is 8.

| Data Element | Field Type |
|---|---|
| When was your baby due? | Date |
| When was your baby delivered? | Date |
| Method of delivery | Select one |
| ○ Options:<br>○ Vaginal Delivery / Assisted Vaginal / Cesarean Section | |
| Reason for C-section (If "Method of delivery" = "C-section") | Select one |
| ○ Cervix Stopped Dilating (*failure to make progress in labor, often because baby is too large for pelvis*)<br>○ Fetal Distress (*abnormal fetal heart rate*)<br>○ Twins or Triplets (*or other multiple births*)<br>○ Breech or Other Fetal Positioning making Vaginal Delivery Difficult (*baby not positioned with head down*)<br>○ Genital Herpes Outbreak<br>○ My Own Choice (*elective*)<br>○ Other *SPECIFY* | |
| Other reason for C-section spec (If "Reason for C-section" = "Other") | Text |
| When were you discharged from the hospital after your baby was born? | Date |
| How was your delivery paid for? | Check all that apply |
| ○ Medicaid<br>○ Personal income (*cash, check, or credit card*)<br>○ Health insurance or HMO (*including insurance from your work or your husband's work*)<br>○ Basic Health Plan<br>○ State-specific<br>○ Other SPECIFY | |
| Other method of payment (If "How was your delivery paid for?" = "Other") | Text |

## 5.15 After Delivery

The following data elements are collected from the Postpartum Q – "After Delivery" section.
The total number of data fields is 30.

| Data Element | Field Type |
|---|---|
| In NICU | Yes/No |
| After your baby was born, how long did he or she stay in the hospital? | Select one |
| ○ Options:<br>○ Less than 1 day / 1 to 2 days / 3 days / 4 days / 5 days / 6 days or more / My baby was not born in a hospital / My baby is still in the hospital | |
| Is your baby alive now? | Yes/No |
| **The following data elements are only collected if "Is your baby alive now?" = Yes** | |

| | |
|---|---|
| Is your baby living with you now? | Yes/No |
| At the hospital where your new baby was born, did you have any of the following? | Check all that apply |
| ○ Hospital staff gave me information about breastfeeding<br>○ My baby stayed in the same room with me at the hospital<br>○ I breastfed my baby in the hospital<br>○ I breastfed my baby in the first hour after my baby was born<br>○ Hospital staff helped me learn how to breastfeed<br>○ My baby was fed only breast milk at the hospital<br>○ Hospital staff told me to breastfeed whenever my baby wanted<br>○ The hospital gave me a gift pack with formula<br>○ The hospital gave me a telephone number to call for help with breastfeeding<br>○ My baby used a pacifier in the hospital<br>○ My baby wasn't born in a hospital<br>○ None of above | |
| About how many hours a day, on average, is your new baby in the same room with someone who is smoking? | Number |
| How do you most often lay your baby down to sleep now? | Select one |
| ○ Options:<br>○ On his or her side / On his or her back / On his or her stomach | |
| How often does your new baby sleep in the same bed with you or anyone else? | Select one |
| ○ Options:<br>○ Always / Often / Sometimes / Rarely / Never | |
| Was your new baby seen by a doctor, nurse, or other health care worker during the first week after he or she left the hospital? | Yes/No |
| Was your new baby seen at home or at a health care facility during the first week after leaving the hospital? | Check all that apply |
| ○ At home<br>○ At a doctor's office, clinic, or other health care facility<br>○ My baby didn't have a medical visit during the first week after leaving the hospital. | |
| Did/Does your new baby suffer from any of the following? | Check all that apply |
| ○ Jaundice (*yellowing of the skin or whites of the eyes*)<br>○ Bowel problems (*e.g. necrotizing enterocolitis*)<br>○ Breathing problems (*e.g. respiratory distress syndrome, bronchopulmonary displasia*)<br>○ Infection (*e.g. sepsis*)<br>○ Neurologic problems (*e.g. brain hemorrhage, intraventricular hemorrhage*)<br>○ Feeding problems (*e.g. needed gastric lavage for feedings*)<br>○ None of above | |
| Has your new baby had a well-baby checkup? | Yes/No |
| Has your new baby gone as many times as you wanted for a well-baby checkup? | Yes/No |
| Did any of these things keep your baby from having a well-baby checkup? (If "Has your new baby gone as many times as you wanted for a well-baby checkup?" = No) | Check all that apply |
| ○ I didn't have enough money or insurance to pay for it<br>○ I couldn't get an appointment<br>○ I had no way to get my baby to the clinic or office | |

| | |
|---|---|
| ○ My baby was too sick to go for routine care<br>○ I didn't have anyone to take care of my other children<br>○ Other SPECIFY<br>○ None of above | |
| Other reason for not getting well-baby checkup? (If "Did any of these things keep your baby from having a well-baby checkup?" = "Other") | Text |
| Did your new baby have any well-baby shots or vaccinations before he or she was 3 months old? | Yes/No |
| How many times has your new baby gone for care when he or she was sick? | Number |
| Where have you taken your new baby when he or she was sick and needed care? | Check all that apply |
| ○ Hospital clinic<br>○ Private doctor's office<br>○ Health department clinic<br>○ Hospital emergency room<br>○ Basic Health Plan<br>○ Other SPECIFY | |
| Other place for sick baby check (If "Where have you taken your new baby when he or she was sick and needed care?" = "Other") | Text |
| Has your new baby gone for care as many times as you wanted when he or she was sick? | Yes/No |
| Do you have health insurance or Medicaid for your new baby? | Yes/No |
| What type of insurance is your new baby covered by? | Check all that apply |
| ○ Medicaid<br>○ Personal income (*cash, check, or credit card*)<br>○ Health insurance or HMO (*including insurance from your work or your husband's work*)<br>○ State Specific<br>○ Basic Health Plan<br>○ Other SPECIFY<br>○ None of above | |
| Other type of insurance (If "What type of insurance is your new baby covered by?" = "Other") | Text |
| Is your new baby in the Child Health Insurance Program (CHIP)? | Yes/No |
| Why didn't you enroll your new baby in CHIP? | Check all that apply |
| ○ I didn't know about the program<br>○ I already had insurance<br>○ I didn't think he or she was eligible<br>○ Other *SPECIFY* | |
| Other reason for not enrolling in CHIP (If "Why didn't you enroll your new baby in CHIP?" = "Other") | Text |
| Since your new baby was born, have you had any medical problem that caused you to go to the hospital and stay overnight? | Yes/No |
| When was the first time you had to go to the hospital and stay overnight after you had your new baby? (If "Since your new baby was born, have you had any medical problem that caused you to go to the hospital and stay overnight?" = Yes) | Date |

| What kind of medical problems caused you to go to the hospital? (If "Since your new baby was born, have you had any medical problem that caused you to go to the hospital and stay overnight?" = Yes) | Check all that apply |
|---|---|
| ○ Options:<br>○ Vaginal bleeding / Fever or infection / Other SPECIFY | |
| Other medical problems (If "What kind of medical problems caused you to go to the hospital?" = "Other") | Text |

# 6 PARTICIPANT QUESTIONAIRE DATA (NEW PROTOCOL)

## 6.1 Health History

The following data elements are collected from the Health History Q.
The total number of data fields is 208.

| Data Element | Field Type |
|---|---|
| **Section: ABOUT YOU** | |
| Date of birth | Date |
| What is your ethnic or racial background? | Check all that apply |
| ○ African American (Black)<br>○ American Indian or Alaska Native<br>○ Asian<br>○ Caucasian (White)<br>○ Hispanic or Latino<br>○ Native Hawaiian or Other Pacific Islander<br>○ Other | |
| Other race spec (If "What is your ethnic or racial background?" = "Other") | Text |
| What is the highest level of education you have completed? | Select one |
| ○ Less than High School<br>○ High School/GED<br>○ Some College<br>○ 2-year College Degree (Associates/ Trade School)<br>○ 4-year College Degree (B.A., B.S.)<br>○ Master's Degree<br>○ Doctoral or Professional Degree (Ph.D.,M.D.,J.D) | |
| Which best describes your annual household income? | Select one |
| ○ Under $15,000<br>○ $15,000- $19,999<br>○ $20,000 - $39,999<br>○ $40,000 - $59,999<br>○ $60,000 - $79,999<br>○ $80,000 or more | |
| What is your employment status? | Check all that apply |
| ○ Employed full-time<br>○ Employed part-time<br>○ Full-time homemaker<br>○ Retired | |

| | |
|---|---|
| ○ Student<br>○ Unemployed<br>○ Other | |
| Other employment status spec (If "What is your employment status?" = "Other") | Text |
| What is your current marital status? | Select one |
| ○ Divorced<br>○ Living together, but not married<br>○ Married<br>○ Separated<br>○ Single, never married<br>○ Widowed | |
| How were you born? | Select one |
| ○ Cesarean section (C-section)<br>○ Vaginal delivery<br>○ Do not know | |
| Were you breast fed? | Yes/No/Do not know |
| How long? (If "Were you breast fed?" = Yes) | Number |
| Are you a twin or multiple? | Yes/No |
| **Section: ABOUT YOUR PREGNANCIES** | |
| How many weeks pregnant are you? | Number |
| What is your approximate due date? | Date |
| When did your last menstrual period start? | Date |
| Do you have health insurance that covers prenatal care? | Yes/No |
| How far into your pregnancy did you first receive prenatal care? | Select one |
| ○ I did not receive prenatal care<br>○ I have not yet received prenatal care but planning to<br>○ Before conception<br>○ 0-4 weeks after conception<br>○ 4 weeks to the end of the first trimester<br>○ During the second trimester<br>○ During the third trimester | |
| Mode of Conception | Check all that apply |
| ○ Natural<br>○ Ovulation (Clomifene, Gonadotrophins)<br>○ IVF (In vitro fertilization)<br>○ Donor Sperm<br>○ Donor Egg | |
| Have you ever been treated for infertility? | Yes/No/Not sure |
| Date of infertility treatment (If "Have you ever been treated for infertility?" = Yes) | Date |
| How many times have you been pregnant in your life (including current pregnancy)? | Number |
| How many babies have you had that were born alive? | Number |
| **The following data elements are collected for each child born alive.**<br>**Subtotal data elements: 11 x 2 = 22 based on 2 pregnancies** | |
| Date of Birth | Date |
| Pregnancy length in weeks | Number |
| Birth weight (pounds) | Number |

| | |
|---|---|
| Delivery | Vaginal/C-section |
| Sex | Male/Female |
| Complications | Check all that apply |
| ○ None<br>○ Preterm Labor<br>○ Preterm Birth<br>○ Gestational Diabetes<br>○ Pre-eclampsia<br>○ Other | |
| Other complications spec (If "Complications" = "Other") | Text |
| How long was baby in hospital after delivery? | Number |
| During pregnancy, did you take prenatal vitamins/supplements containing folic acid? | Yes/No/Not sure |
| Did you breast-feed this child? | Yes/No/Not sure |
| For how long? (If "Did you breast-feed this child?" = Yes) | Select one |
| ○ Less than 1 month<br>○ 1-3 months<br>○ 3- 6 months<br>○ 6 months to a year<br>○ Over 1 year | |
| **The data elements collected for each child stop here.** | |
| Have you ever had an ectopic or tubal pregnancy? | Yes/No/Not sure |
| How many ectopic or tubal pregnancies? (If "Have you ever had an ectopic or tubal pregnancy?" = Yes) | Number |
| Have you ever had an abortion? | Yes/No/Not sure |
| How many abortions? (If "Have you ever had an abortion?" = Yes) | Number |
| Have you ever had a miscarriage or stillbirth? | Yes/No/Not sure |
| How many stillbirths? (If "Have you ever had a miscarriage or stillbirth?" = Yes) | Number |
| Have you had any twin or multiple pregnancies? | Yes/No |
| How many twin or multiple pregnancies? (If "Have you had any twin or multiple pregnancies?" = Yes) | Number |
| **Section: ABOUT YOUR GYNECOLOGICAL HISTORY** | |
| Do you currently have abnormal vaginal discharge? | Yes/No/Not sure |
| Do you currently have a bad-smelling vaginal odor? | Yes/No/Not sure |
| Do you currently have vaginal itching? | Yes/No/Not sure |
| Have you ever been diagnosed with recurrent bacterial vaginosis (BV) (more than once in one year)? | Yes/No/Not sure |
| Have you ever been diagnosed with recurrent yeast infections (4 or more infections in one year)? | Yes/No/Not sure |
| In the last two years, were you using any method of birth control? | Yes/No/Not sure |
| What birth control method? (If "In the last two years, were you using any method of birth control?" = Yes) | Check all that apply |
| ○ Diaphragm or Cervical Cap<br>○ Condoms<br>○ Natural Family Planning (Tracking your ovulation)<br>○ Spermicide | |

| | |
|---|---|
| ○ Sponge<br>○ Partner had a Vasectomy<br>○ Withdrawal<br>○ Tubal Ligation (Tubes Tied)<br>○ Depo-Provera Injections (the shot)<br>○ Implant under your skin (Implanon/Norplant)<br>○ Copper IUD (ParaGard)<br>○ Plastic IUD (Containing hormones like Mirena)<br>○ Patch<br>○ Vaginal Ring (NuvaRing)<br>○ Morning-after pill (Plan B)<br>○ Pills<br>○ Other | |
| Birth control pills spec (If "What birth control method" = "Pills") | Text |
| Other birth control method spec (If "What birth control method" = "Other") | Text |
| On average, during the past year, how often have you douched? | Select one |
| ○ Once a day<br>○ 2-6 times per week<br>○ Once a week<br>○ 1-3 times per month<br>○ Less than once a month<br>○ Never | |
| When was the last time you douched? | Select one |
| ○ Within the last 24 hours<br>○ 1-2 days ago<br>○ 3-7 days ago<br>○ 1-3 weeks ago<br>○ More than 1 month ago<br>○ More than 1 year ago or never | |
| **Section: ABOUT YOUR SEXUAL HISTORY** | |
| How many sexual partners have you had in your lifetime? | Select one |
| ○ Options:<br>○ 0 / 1 / 2 / 3-5 / 6-10 / 11-20 / 21+ | |
| How many sexual partners have you had in the past year? | Select one |
| ○ Options:<br>○ 0 / 1 / 2 / 3-5 / 6-10 / 11-20 / 21+ | |
| How many sexual partners have you had in the past month? | Select one |
| ○ Options:<br>○ 0 / 1 / 2 / 3-5 / 6-10 / 11-20 / 21+ | |
| How old were you when you first had sex? | Number |
| What is the sex of your current partner(s) (sex within last 6 months)? | Check all that apply |
| ○ Male<br>○ Female<br>○ Other<br>○ No sexual partners | |
| Other sexual partners spec (If "What is the sex of your current partner(s) (sex within last 6 months)?" = "Other") | Text |

| |
|---|
| **The following data elements collect "On average, during the past year, how often have you ___" with a scale of "Once a day; 2-6 times per week; Once a week; 1-3 times per month; Less than once a month; Never".**<br>**Subtotal data elements: 6** |
| ✓ Had vaginal sex?<br>✓ Performed oral sex?<br>✓ Received oral sex?<br>✓ Had anal sex?<br>✓ Other vaginal penetration? (ex: fingers, toys)<br>✓ Used vaginal lubricants? (ex: KY Jelly, Astroglide) |
| **The following data elements collect "When was the last time you ___" with a scale of "Within the last 24 hours; 1-2 days ago; 3-7 days ago; 1-3 weeks ago; More than 1 month ago; More than 1 year ago or never".**<br>**Subtotal data elements: 6** |
| ✓ Had vaginal sex?<br>✓ Performed oral sex?<br>✓ Received oral sex?<br>✓ Had anal sex?<br>✓ Other vaginal penetration? (ex: fingers, toys)<br>✓ Used vaginal lubricants? (ex: KY Jelly, Astroglide) |
| **Section: ABOUT YOUR MEDICAL HISTORY** |
| Do you have any of following medical conditions? — Check all that apply |
| o Appendicitis (Please specify below)<br>o Beta (Group B) Streptococcus<br>o Blood Disorder (ex: sickle cell anemia)<br>o Cardiac Disease<br>o Cancer (Please specify below)<br>o Chicken Pox<br>o Chronic Respiratory Disease<br>o Crohn's Disease<br>o Cytomegalovirus (CMV)<br>o Diabetes Type 1<br>o Diabetes Type 2<br>o Dilation and Curettage (D&C)<br>o Endometriosis<br>o Fibroid tumor(s)<br>o Fifth Disease<br>o Gestational Diabetes<br>o Gum Disease<br>o High blood pressure (Please specify below)<br>o High Cholesterol<br>o Hepatitis A<br>o Hepatitis B<br>o Hepatitis C<br>o HIV or AIDS<br>o Listeriosis<br>o Lupus erythematous<br>o Mental Illness (Ex: depression, anxiety)<br>o Migraines |

| | |
|---|---|
| o Obesity<br>o Ovarian Cyst<br>o Polycystic Ovary Syndrome<br>o Renal (Kidney) disease<br>o Rheumatoid Arthritis<br>o Seizure Disorder<br>o Thyroid disease<br>o Tuberculosis (TB)<br>o Toxic Shock Syndrome (TSS)<br>o Toxoplasmosis<br>o Ulcerative Colitis<br>o Other (Please specify below) | |
| Appendicitis - Ruptured? (If "Do you have any of following medical conditions" = "Appendicitis") | Yes/No |
| Cancer spec (If "Do you have any of following medical conditions" = "Cancer") | Check all that apply |
| o Cervical Cancer<br>o Ovarian Cancer<br>o Uterine Cancer<br>o None of the above | |
| High blood pressure spec (If "Do you have any of following medical conditions" = "High blood pressure") | Select one |
| o During pregnancy<br>o Outside of pregnancy | |
| Other medical history spec (If "Do you have any of following medical conditions" = "Other") | Text |
| What was the approximate date of your last Pap Test? | Date |
| **Have you ever been diagnosed with any of the following? The following data elements are collected with options of "Yes/No/Not sure".<br>Lifetime number of diagnosis with a scale of "1; 2-4; 5+", and "Month/Year" of most recent diagnosis are also collected for the medical condition checked "Yes".<br>Subtotal data elements: 13 x 3 = 39** | |
| ✓ Gonorrhea<br>✓ Chlamydia<br>✓ Syphilis<br>✓ Pelvic Inflammatory disease<br>✓ Vaginitis<br>✓ Abnormal Pap smear<br>✓ Bacterial vaginosis<br>✓ Urinary Tract Infection<br>✓ Trichonmoniasis<br>✓ Yeast Infection<br>✓ HPV<br>✓ Genital Warts<br>✓ Genital Herpes | |
| Are you currently taking any medications? | Yes/No |
| Medications spec (If "Are you currently taking any medications?" = Yes) | Text |
| Are you currently taking any supplements or pills (Probiotics, Multivitamins, Calcium, Fe, B, C, E, Herbal)? | Yes/No/Not sure |

| | |
|---|---|
| During this pregnancy, have you taken prenatal vitamins or supplements that contain folic acid? | Yes/No/Not sure |
| Have you received the HPV Vaccination (Gardasil, Cervarix)? | Yes/No/Not sure |
| **Have you taken any of the following medications in the past 6 months? "Most recent date taken" is also collected for the medications checked "Yes".**<br>**Subtotal data elements: 17 x 2 = 34** | |
| Antibiotics? | Yes/No/Not sure |
| Metronidazole (Ex: Flagyl)? | Yes/No/Not sure |
| Penicillin (Ex: Amoxicillin, Ampicillin)? | Yes/No/Not sure |
| Cephalosporins (Ex: Keflex, Cefzil, Suprax)? | Yes/No/Not sure |
| Nitrofurantoin (Ex: Macrobid)? | Yes/No/Not sure |
| Quinolones (Ex: Cipro, Levaquin, Floxacin)? | Yes/No/Not sure |
| Macrolides (Ex: Azithromycin, Erythromycin)? | Yes/No/Not sure |
| Sulfa Antibiotics (Ex: Bactrim, Septra)? | Yes/No/Not sure |
| Tetracyclines (Ex: Doxycycline, Minocycline)? | Yes/No/Not sure |
| Other Antibiotics? | Yes/No/Not sure |
| Other Antibiotics spec | Text |
| Doctor-prescribed yeast infection medication? | Yes/No/Not sure |
| Over-the-counter yeast infection medication (Ex: Monistat)? | Yes/No/Not sure |
| Insulin? | Yes/No/Not sure |
| Insulin spec (If "Insulin?" = Yes) | Text |
| Oral steroids? | Yes/No/Not sure |
| Oral steroids spec (If "Oral steroids?" = Yes) | Text |
| **Section: ABOUT YOUR LIFESTYLE** | |
| Have you smoked more than 100 cigarettes (about 5 packs) in your lifetime? | Yes/No |
| At what age did you start smoking? (If "Have you smoked more than 100 cigarettes (about 5 packs) in your lifetime?" = Yes) | Number |
| Do you currently smoke? (If "Have you smoked more than 100 cigarettes (about 5 packs) in your lifetime?" = Yes) | Select one |
| ○ Yes (not trying to quit)<br>○ Yes (trying to quit)<br>○ No | |
| During the last 30 days, on average, how many cigarettes have you smoked per day? (If "Have you smoked more than 100 cigarettes (about 5 packs) in your lifetime?" = Yes) | Number |
| If you don't currently smoke, what age did you stop smoking? (If "Do you currently smoke?" = No) | Number |
| How often are you exposed to second hand smoke? | Select one |
| ○ Almost every day<br>○ Every day<br>○ Rarely<br>○ Never | |
| In the last year, have you used marijuana, illegal street drugs, or abused prescription medication? | Yes/No |

| | |
|---|---|
| Drug spec (If "In the last year, have you used marijuana, illegal street drugs, or abused prescription medication?" = Yes) | Text |
| Average number of days used drugs (If "In the last year, have you used marijuana, illegal street drugs, or abused prescription medication?" = Yes) | Number |
| **The following data elements collect "On how many occasions have you had any alcohol (beer, malt liquor, wine coolers, mixed drinks, or wine) ____?" with a scale of "0 times; 1-2 times; 3-5 times; 6-9 times; 10-19 times; 20+ times".**<br>**Subtotal data elements: 3** | |
| ✓ In the last 12 months?<br>✓ In the last 30 days?<br>✓ In the past week? | |
| Do you have any pets living inside your home? | Check all that apply |
| ○ Options:<br>○ Dogs / Cats / Others / None | |
| Other pets spec (If "Do you have any pets living inside your home?" = "Others") | Text |
| How many dogs? (If "Do you have any pets living inside your home?" = "Dogs") | Number |
| How many cats? (If "Do you have any pets living inside your home?" = "Cats") | Number |
| How many of the other type of pet? (If "Do you have any pets living inside your home?" = "Others") | Number |
| **The following data elements collect "On average, since you've been pregnant, how many times per week did you take part in ___" with a scale of "0 times; 1-2 times; 3-4 times; 5-6 times; 7+ times".**<br>**Subtotal data elements: 3** | |
| ✓ Vigorous physical activity? (ex: running, swimming, heavy yard work)<br>✓ Moderate physical activity? (ex: brisk walking, hiking, gardening, golf)<br>✓ Light physical activity? (ex: shopping, light house work) | |
| **The following data elements collect "On average, since you've been pregnant, how often did you eat the following foods?" with a scale of "5+ servings per day; 3-4 servings per day; 1-2 servings per day; 3-4 servings per week; 1-2 servings per week; Less than 1 servings per week".**<br>**Subtotal data elements: 5** | |
| ✓ Yogurt (1 cup)?<br>✓ Milk (1 cup)<br>✓ Cheese (2 oz./ ~2 slices)?<br>✓ Ice cream (1/2 cup)?<br>✓ Other dairy (not eggs)? | |
| **The following data elements collect "Have you been on any of the following diets in the past year?" with options of "Yes/No/Not sure".**<br>**Subtotal data elements: 8** | |
| ✓ Low-fat diet<br>✓ Low-carb diet (ex: Atkins)<br>✓ Low-calorie diet<br>✓ Vegetarian diet<br>✓ Vegan diet<br>✓ Gluten-free diet<br>✓ Physician-prescribed diet<br>✓ Other diet | |

| | |
|---|---|
| Other diet spec (If "Have you been on any of the following diets in the past year?" = "Other") | Text |
| Have you been experiencing any of the following? | Check all that apply |
| ○ An abnormal amount of stress<br>○ Trouble sleeping or falling asleep<br>○ Depression<br>○ Anxiety<br>○ Little or no energy<br>○ Poor appetite<br>○ Trouble concentrating<br>○ Mood swings | |
| **The following data element collect "Considering everything you have to deal with in your life, how much do you think the following are source of stress compared with other people?" with a scale of "Much less; A Bit Less; About Average; A Bit More; Much More".**<br>**Subtotal data elements: 6** | |
| ✓ Money worries<br>✓ Worries about having a place to live<br>✓ Worries about my relationship with family or people close to me<br>✓ Worries about my health<br>✓ The burden of taking care of children, relatives or people close to me<br>✓ Worries about my work | |
| **The following data elements collect "In the last month, how often have you ___" with a scale of "Never; Almost Never; Sometimes; Fairly Often; Very Often".**<br>**Subtotal data elements: 10** | |
| ✓ Been upset because of something that happened unexpectedly?<br>✓ Felt that you were unable to control the important things in your life?<br>✓ Felt nervous and "stressed'?<br>✓ Felt confident about your ability to handle your personal problems?<br>✓ Felt that things were going your way?<br>✓ Found that you could not cope with all the things that you had to do?<br>✓ Been able to control irritations in your life?<br>✓ Felt that you were on top of things?<br>✓ Been angered because of things that were outside of your control?<br>✓ Felt difficulties were piling up so high that you could not overcome them? | |
| Compared with the average American woman, how would you rate the amount of stress you have to deal with in your life right now? | Select one |
| ○ Much less stress than most people<br>○ A bit less stress than most people<br>○ About average stress<br>○ A bit more stress than most people<br>○ Much more stress than most people | |
| Concerning your health, lifestyle, or pregnancy, is there anything we haven't asked about that you think we should know? | Text |

## 6.2 Dietary Assessment

The following data elements are collected from the Dietary Assessment Q.
The total number of data fields is 176.

| Data Element | Field Type |
|---|---|
| Do you currently take multi-vitamins? | Yes/No |
| How many do you take per week? (If "Do you currently take multi-vitamins?" = Yes) | Select one |
| ○ Options:<br>○ 2 or less / 3-5 / 6-9 / 10 or more | |
| What specific brand (or equivalency) do you usually take? (If "Do you currently take multi-vitamins?" = Yes) | Select one |
| ○ Centrum Silver<br>○ Centrum<br>○ Theragran M<br>○ One-A-Day Essential<br>○ Other | |
| Other multi-vitamins spec (If "What specific brand (or equivalency) do you usually take?" = "Other") | Text |
| **The following data elements collect "not counting multi-vitamins, do you take any of the following preparations?" with a scale of "No; Yes; Yes, seasonally only; Yes, most months; Less than 10,000 IU; 10,000 to 15,000 IU; 16,000 to 22,000 IU; 23,000 IU or more; Don't know". Subtotal data elements: 9** | |
| ✓ Vitamin A<br>✓ Potassium<br>✓ Vitamin C<br>✓ Vitamin B6<br>✓ Vitamin E<br>✓ Calcium<br>✓ Selenium<br>✓ Vitamin D<br>✓ Zinc | |
| Are there other supplements that you take on a regular basis? | Check all that apply |
| ○ Metamucil/Citrucel<br>○ Cod Liver Oil<br>○ Vitamin B12<br>○ Flax Seed Oil<br>○ Flax Seed<br>○ Beta-carotene<br>○ Magnesium<br>○ Fish oil<br>○ Niacin<br>○ Chromium<br>○ Lecithin<br>○ Coenzyme Q10<br>○ Choline<br>○ Folic Acid<br>○ B-Complex<br>○ Lycopene<br>○ DHEA<br>○ Iron<br>○ Other | |

| | |
|---|---|
| Other supplements spec (If "Are there other supplements that you take on a regular basis?" = Yes) | Text |
| How many teaspoons of sugar do you add to your beverages or food each day? | Number |
| What brand and type of cold breakfast cereal do you usually eat? | Text |
| What form of margarine or spread do you usually use (exclude pure butter)? | Text |
| Form of margarine | Select one |
| ○ Options:<br>○ Stick / Tub / Spray / Squeeze (liquid) | |
| Type of margarine | Select one |
| ○ Options:<br>○ Reg / Light / Nonfat | |
| **The following data elements collect the diet behavior during the past year with the scale of "Never or less than once per month, 1-3 per month; 1 per week; 2-4 per week; 5-6 per week; 1 per day; 2-3 per day; 4-5 per day; 6+ per day".** | |
| **DAIRY FOODS**<br>**Subtotal data elements: 14** | |
| ✓ Skim milk (8 oz. glass)<br>✓ 1 or 2% milk (8 oz. glass)<br>✓ Whole milk (8 oz. glass)<br>✓ Soy milk (8 oz. glass)<br>✓ Cream, e.g., coffee, whipped or sour cream (1 Tbs)<br>✓ Non-dairy coffee whitener (1 Tbs)<br>✓ Frozen yogurt, sherbet or low-fat ice cream (1 cup)<br>✓ Regular ice cream (1 cup)<br>✓ Yogurt: Low-carb, artificially sweeten or plain<br>✓ Yogurt: Sweetened - with fruit or other flavoring<br>✓ Spreads added to food or bread; exclude use in cooking: Margarine<br>✓ Cottage or ricotta cheese (1/2 cup)<br>✓ Cream cheese (1 oz.)<br>✓ Other cheese, e.g., American, cheddar, etc., plain or as part of a dish (1 slice or 1 oz. serving) | |
| What type of cheese do you usually eat? | Select one |
| ○ Options:<br>○ Soy / Regular / Low fat or Lite / Nonfat / None | |
| **FRUITS**<br>**Subtotal data elements: 17** | |
| ✓ Raisins (1 oz. or small pack) or grapes (1/2 cup)<br>✓ Prunes or dried plums (6 prunes or 1/4 cup)<br>✓ Prune juice (small glass)<br>✓ Bananas (1)<br>✓ Cantaloupe (1/4 melon)<br>✓ Avocado (1/2 fruit or 1/2 cup)<br>✓ Fresh apples or pears (1)<br>✓ Apple juice or cider (small glass)<br>✓ Oranges (1)<br>✓ Orange juice (small glass) - Calcium fortified<br>✓ Orange juice (small glass) - Regular (not calcium fortified) | |

- ✓ Grapefruits (1/2) or grapefruit juice (small glass)
- ✓ Other fruit juices (small glass)
- ✓ Strawberries, fresh, frozen, or canned (1/2 cup)
- ✓ Blueberries, fresh, frozen or canned (1/2 cup)
- ✓ Peaches or plums (1 fresh or 1/2 cup canned)
- ✓ Apricots (1 fresh, 1/2 cup canned or 5 dried)

**VEGETABLES**
**Subtotal data elements: 28**

- ✓ Tomatoes (2 slices)
- ✓ Tomato or V-8 juice (small glass)
- ✓ Tomato sauce (1/2 cup) e.g., spaghetti sauce
- ✓ Salsa, picante or taco sauce (1/4 cup)
- ✓ String beans (1/2 cup)
- ✓ Beans or lentils, baked, dried or soup (1/2 cup)
- ✓ Tofu, soy burger, soybeans, miso or other soy protein
- ✓ Peas or lima beans (1/2 cup fresh, frozen, canned)
- ✓ Broccoli (1/2 cup)
- ✓ Cauliflower (1/2 cup)
- ✓ Cabbage or coleslaw (1/2 cup)
- ✓ Brussels sprouts (1/2 cup)
- ✓ Carrots, raw (1/2 carrot or 2-4 sticks)
- ✓ Carrots, cooked 1/2 cup) or carrot juice (2-3 oz.)
- ✓ Corn (1 ear or 1/2 cup frozen or canned)
- ✓ Mixed or stir-fry vegetables (1/2 cup), veg. soup (1 cup)
- ✓ Yams or sweet potatoes (1/2 cup)
- ✓ Dark orange (winter) squash (1/2 cup)
- ✓ Eggplant, zucchini or other summer squash (1/2 cup)
- ✓ Kale, mustard greens or chard (1/2 cup)
- ✓ Spinach, cooked (1/2 cup)
- ✓ Spinach, raw as in salad (1 cup)
- ✓ Iceberg or head lettuce (1 serving)
- ✓ Romaine or leaf lettuce (1 serving)
- ✓ Celery (2-3 sticks)
- ✓ Peppers: green, yellow or red (3 slices)
- ✓ Onions as a garnish or in a salad (1 slice)
- ✓ Onions as a cooked vegetable, rings or soup (1/2 cup)

**EGGS, MEAT, ETC.**
**Subtotal data elements: 19**

- ✓ Eggs (1) - Omega-3 fortified including yolk
- ✓ Eggs (1) - Regular eggs including yolk
- ✓ Beef or pork hot dogs (1)
- ✓ Chicken or turkey hot dogs or sausage (1)
- ✓ Chicken/turkey sandwich or frozen dinner
- ✓ Other chicken or turkey, with skin (3 oz.)
- ✓ Other chicken or turkey, without skin (3 oz.)- including ground
- ✓ Bacon (2 slices)
- ✓ Salami, bologna, or other processed meat sandwiches
- ✓ Other processed meats, e.g., sausage, kielbasa, etc. (2 oz. or 2 small links)
- ✓ Hamburger (1 patty) - Lean or extra lean

- ✓ Hamburger (1 patty) – Regular
- ✓ Beef, pork, or lamb as a sandwich or mixed dish, e.g., stew, casserole, lasagna, frozen dinners, etc.
- ✓ Pork as a main dish, e.g., ham or chops (4-6 oz.)
- ✓ Canned tuna fish (3-4 oz.)
- ✓ Breaded fish cakes, pieces, or fish sticks (1 serving, store bought)
- ✓ Shrimp, lobster, scallops as a main dish
- ✓ Dark meat fish, e.g., tuna steak, mackerel, salmon, sardines, bluefish, swordfish (3-5 oz.)
- ✓ Other fish, e.g., cod, haddock, halibut (3-5 oz.)

**BREADS, CEREALS, STARCHES**
**Subtotal data elements: 17**

- ✓ Cold breakfast cereal (1 serving)
- ✓ Cooked oatmeal/ cooked oat bran (1 cup)
- ✓ Bread (1 slice) - White bread, including pita
- ✓ Bread (1 slice) - Rye/Pumpernickel
- ✓ Bread (1 slice) - Whole wheat, oatmeal, other whole grain
- ✓ Crackers, regular or low-fat e.g., Triscuits, Ritz (6)
- ✓ Bagels, English muffins, or rolls (1)
- ✓ Muffins or biscuits (1)
- ✓ Pancakes or waffles (2 small pieces)
- ✓ Brown rice (1 cup)
- ✓ White rice (1 cup)
- ✓ Pasta, e.g., spaghetti, noodles, couscous, etc., (1 cup)
- ✓ Tortillas (2)
- ✓ French Fries (6 oz. or 1 serving)
- ✓ Potatoes, baked boiled (1) or mashed (1 cup)
- ✓ Potato chips or corn/tortilla chips (small bag or 1 oz.)
- ✓ Pizza (2 slices)

**CARBONATED BEVERAGES**
**Subtotal data elements: 4**

- ✓ Low-calorie beverage with caffeine, e.g., Diet Coke, Diet Mt. Dew
- ✓ Other low-cal bev. without caffeine, e.g., Diet 7-Up
- ✓ Carbonated beverage with caffeine & sugar, e.g., Coke, Pepsi, Mt. Dew, Dr. Pepper
- ✓ Other carbonated beverage with sugar, e.g., 7-Up, Root Beer, Ginger Ale, Caffeine-Free Coke

**OTHER BEVEREAGES**
**Subtotal data elements: 12**

- ✓ Other sugared beverages: punch, lemonade, sports drinks, or sugared ice tea (1 glass, bottle, can)
- ✓ Beer, regular (1 glass, bottle, can)
- ✓ Light Beer, e.g., Bud Light (1 glass, bottle, can)
- ✓ Red wine (5 oz. glass)
- ✓ White wine (5 oz. glass)
- ✓ Liquor, e.g., vodka, gin, etc. (1 drink or shot)
- ✓ Water: bottled, sparkling, or tap (8 oz. cup)
- ✓ Herbal tea or decaffeinated tea (8 oz. cup)
- ✓ Tea with caffeine (8 oz. cup), including green tea
- ✓ Decaffeinated coffee (8 oz. cup)
- ✓ Coffee with caffeine (8 oz. cup)
- ✓ Dairy coffee drink (hot/cold) e.g., Cappuccino (16 oz.)

**SWEETS, BAKED GOODS, MISCELLANEOUS**
**Subtotal data elements: 33**

| |
|---|
| ✓ Milk chocolate (bar or pack), e.g., Hershey's, M&M's<br>✓ Dark chocolate, e.g., Hershey's Dark or Dove Dark<br>✓ Candy bars, e.g., Snickers, Milky Way, Reese's<br>✓ Candy without chocolate (1 oz.)<br>✓ Cookies (1) - Fat free or reduced fat<br>✓ Cookies (1) – Other<br>✓ Brownies (1)<br>✓ Doughnuts (1)<br>✓ Cake - Fat free or reduced fat<br>✓ Cake – Other<br>✓ Pie, homemade or readymade (slice)<br>✓ Jams, jellies, preserves, syrup, or honey (1 Tbs)<br>✓ Peanut butter (1 Tbs)<br>✓ Popcorn (3 cups) - Fat free or light<br>✓ Sweet roll, coffee cake or other pastry (serving) - Fat free or reduced fat<br>✓ Sweet roll, coffee cake or other pastry (serving) – Other<br>✓ Breakfast bars, e.g., Nutrigrain, granola, Kashi (1)<br>✓ Energy bars, e.g., Clif, Luna, Glucerna, Powerbar (1)<br>✓ Low carb bars, e.g., Atkins, Zone, South Beach (1)<br>✓ Pretzels (1 small bag or serving)<br>✓ Peanuts (small packet or 1 oz.)<br>✓ Walnuts (1 oz.)<br>✓ Other nuts (small packet or 1 oz.)<br>✓ Oat bran, added to food (1 Tbs)<br>✓ Other bran (wheat, etc.), added to food (1 Tbs)<br>✓ Chowder or cream soup (1 cup)<br>✓ Ketchup or red chili sauce (1 Tbs)<br>✓ Splenda (1 packet)<br>✓ Other artificial sweetener (1 packet)<br>✓ Olive oil added to food or bread (1 Tbs)<br>✓ Low-fat or fat-free mayonnaise (1 Tbs)<br>✓ Regular mayonnaise (1 Tbs)<br>✓ Salad dressing (1-2 Tbs) |
| Type of salad dressing — Select one |
| ○ Nonfat<br>○ Low-fat<br>○ Olive oil<br>○ Other vegetable oil |
| **The following data elements collect the diet behavior during the past year with the scale of "Never; Less than 1/mo; 1/mo; 2-3/mo; 1/week or more".**<br>**Subtotal data elements: 2** |
| ✓ Liver: (beef, calf or pork 4 oz.)<br>✓ Liver: (chicken or turkey 1 oz.) |
| How often do you eat fried or sautéed food at home? (Exclude Pam -type spray) — Select one |
| ○ Less than once a week<br>○ 1-3 times per week<br>○ 4-6 times per week<br>○ Daily |

| What kind of fat is usually used for frying and sautéing at home? (Exclude Pam -type spray) | Select one |
|---|---|
| ○ Real butter<br>○ Margarine<br>○ Olive oil<br>○ Vegetable oil<br>○ Veg. shortening<br>○ Lard<br>○ N/A | |
| What kind of fat is usually used for baking at home? | Select one |
| ○ Real butter<br>○ Margarine<br>○ Olive oil<br>○ Vegetable oil<br>○ Veg. shortening<br>○ Lard<br>○ N/A | |
| What type of cooking oil is usually used at home? | Text |
| How often do you eat deep fried chicken, fish, shrimp, clams or onion rings away from home? | Select one |
| ○ Less than once a week<br>○ 1-3 times per week<br>○ 4-6 times per week<br>○ Daily | |
| How often do you eat toasted breads, bagel or English muffin (e.g., slice or 1 half bagel)? | Select one |
| ○ Less than once a week<br>○ 1-3 times per week<br>○ 4-6 times per week<br>○ Daily | |
| Are there any other important foods that you usually eat at least once per week? | Text |
| Servings per week of other important foods that you usually eat at least once per week | Text |

## 6.3 Review of Systems

The following data elements are collected from the Review of Systems Q.
The total number of data fields is 98.

| **Data Element** | **Field Type** |
|---|---|
| How many weeks pregnant are you? | Number |
| During this pregnancy, have you been told by a health care professional that you have had high blood pressure or hypertension? | Select one |
| ○ Yes, during my 1st trimester<br>○ Yes, during my 2nd trimester<br>○ Yes, during my 3rd trimester<br>○ No, I have not been told my blood pressure is/was high. | |

| | |
|---|---|
| ○ Not sure | |
| Since your last study visit, has a health care professional told you your blood sugar was high or that you had diabetes? | Yes/No/Not sure |
| Since your last study visit, how many alcoholic drinks have you had in an average week? | Number |
| Since your last study visit, how many cigarettes have you smoked in an average day? | Number |
| Since your last study visit, how often have you been exposed to second hand smoke? | Select one |
| ○ Options:<br>○ Every day / Almost every day / Rarely / Never | |
| Since your last study visit, have you been exposed to any potentially dangerous chemicals (pesticides, etc.)? | Yes/No |
| List those chemicals exposed to (If "Since your last study visit, have you been exposed to any potentially dangerous chemicals (pesticides, etc.)?" = Yes) | Text |
| Since your last study visit, have you lost or gained weight, or has your weight stayed the same? | Select one |
| ○ I have LOST weight since my last study visit.<br>○ I have GAINED weight since my last study visit.<br>○ My weight has NOT changed since my last study visit.<br>○ Not sure | |
| How many lbs of weight lost/gained? (If "Since your last study visit, have you lost or gained weight, or has your weight stayed the same?" = "LOST" or "GAINED") | Select one |
| ○ 0-5 lbs<br>○ 5-10 lbs<br>○ 10-15 lbs<br>○ More than 15 lbs | |
| **The following data elements collect "Have you been on any of the following diets in the past year?" with options of "Yes/No/Not sure".**<br>**Subtotal data elements: 8** | |
| ✓ Low-fat diet<br>✓ Low-carb diet (ex: Atkins)<br>✓ Low-calorie diet<br>✓ Vegetarian diet<br>✓ Vegan diet<br>✓ Gluten-free diet<br>✓ Physician-prescribed diet<br>✓ Other diet | |
| Other diet spec (If "Have you been on any of the following diets in the past year?" = "Other") | Text |
| Since your last study visit, have you had a fever? If yes, what was your highest temperature? | Select one |
| ○ No, I have not had a fever since my last study visit.<br>○ Yes, 98F-100F<br>○ Yes, 101F-103F<br>○ Yes, over 103F<br>○ Not sure | |

| In the last two months (or since your last study visit), have you had any of the following infections? | Check all that apply |
|---|---|
| ○ Bacterial Vaginosis (BV)<br>○ Beta (Group B) Streptococcus<br>○ Chicken Pox<br>○ Chlamydia<br>○ Cytomegalovirus (CMV)<br>○ Ear/Sinus Infection<br>○ Genital Warts<br>○ Genital Herpes<br>○ Gonorrhea<br>○ Fifth Disease<br>○ HIV/AIDS<br>○ HPV<br>○ Listeriosis<br>○ Pelvic Inflammatory disease<br>○ Syphilis<br>○ Trichomoniasis<br>○ Toxoplasmosis<br>○ Urinary Tract Infection<br>○ Vaginitis<br>○ Yeast Infection<br>○ Other | |
| Other infections spec (If "In the last two months (or since your last study visit), have you had any of the following infections?" = "Other") | Text |
| **The following data elements collect "In the last two months (or since your last study visit), have you taken any of the following antibiotics?" with options of "Currently taking; Recently taken in the last 2 months". The date of medication taken is also collected if either option is checked. Subtotal data elements: 9 x 2 = 18** | |
| ✓ Cephalosporins (eg. Keflex, Cefzil, Suprax)<br>✓ Macrolides (eg. Azithromycin, Erythromycin)<br>✓ Metronidazole (eg. Flagyl)<br>✓ Nitrofurantoin (eg. Macrobid)<br>✓ Penicillin (eg. Amoxicillin, Ampicillin)<br>✓ Quinolones (eg. Cipro, Levaquin, Floxacin)<br>✓ Sulfa Antibiotics (Ex: Bactrim, Septra)<br>✓ Tetracyclines (Ex: Doxycycline, Minocycline)<br>✓ Other Antibiotics | |
| Other antibiotics spec (If "In the last two months (or since your last study visit), have you taken any of the following antibiotics?" = "Other Antibiotics") | Text |
| Since your last study visit, have you taken any of the following medications? | Check all that apply |
| ○ Doctor-prescribed yeast infection medication?<br>○ Over-the-counter yeast infection medication (Ex: Monistat)<br>○ Insulin?<br>○ Oral steroids? | |
| Insulin spec (If "Since your last study visit, have you taken any of the following medications?" = "Insulin?") | Text |

| | |
|---|---|
| Oral steroids spec (If "Since your last study visit, have you taken any of the following medications?" = "Oral steroids?") | Text |
| Do you currently have abnormal vaginal discharge? | Yes/No/Not sure |
| Do you currently have bad-smelling vaginal odor? | Yes/No/Not sure |
| Do you currently have vaginal itching? | Yes/No/Not sure |
| Are you currently taking any other new medications, supplements, or pills? | Yes/No |
| How many new medications are you taking? (If "Are you currently taking any other new medications, supplements, or pills?" = Yes) | Number |
| New medications spec (If "How many new medications are you taking?" > 0) | Text |
| Since your last study visit, have you visited the emergency room or been hospitalized due to an accident or illness? | Yes/No |
| Why were you hospitalized? (If "Since your last study visit, have you visited the emergency room or been hospitalized due to an accident or illness?" = Yes) | Text |
| Since your last study visit, has a health care professional recommended or prescribed bed rest? | Yes/No/Not sure |
| Since your last study visit, have you lost or terminated your pregnancy? | Select one |
| ○ No<br>○ Yes, I had a miscarriage/spontaneous abortion<br>○ Yes, I had an induced abortion<br>○ Yes, I lost my pregnancy for other reasons | |
| Other reason spec (If "Since your last study visit, have you lost or terminated your pregnancy?" = "Other reason") | Text |
| **The following data elements collect "Have you noticed any of the following during this pregnancy?" with options of "Yes, during my 1st trimester; Yes, during my 2nd trimester; Yes, during my 3rd trimester; No, I have not experienced".**<br>**Subtotal data elements: 8** | |
| ✓ Vaginal bleeding<br>✓ Abnormal vaginal discharge<br>✓ Bad-smelling vaginal odor<br>✓ Vaginal itching<br>✓ Contractions<br>✓ I thought I was going into labor (false labor)<br>✓ Diarrhea<br>✓ Respiratory symptoms (trouble breathing, etc.) | |
| Since the last study visit, did your water break? Have you had a premature rupture of membranes? | Select one |
| ○ Yes, membranes ruptured 1-18 hours before labor (PROM)<br>○ Yes, membranes ruptured more than 18 hours before labor (Prolonged PROM)<br>○ Yes, membranes ruptured before 37 weeks of pregnancy (Preterm PROM)<br>○ No, there has been no premature rupture of membranes. | |
| Has a healthcare professional diagnosed you with hyperemesis gravidarum (HG)? | Select one |
| ○ Yes, I have been diagnosed with hyperemesis.<br>○ No, I have not been diagnosed with hyperemesis, but I have symptoms.<br>○ No, I have not been diagnosed with hyperemesis, and I do not have symptoms.<br>○ Not sure | |

| | |
|---|---|
| During this pregnancy, has your healthcare professional prescribed you with progesterone? | Yes/No/Not sure |
| During this pregnancy, has your healthcare professional placed a cervical cerclage (stitch in cervix)? | Yes/No/Not sure |
| Have you been sexually active during your pregnancy? | Yes/No |
| **The following data elements collect "When was the last time you ___" with a scale of "Within the last 24 hours; 1-2 days ago; 3-7 days ago; 1-3 weeks ago; More than 1 month ago; More than 1 year ago or never".**<br>**Subtotal data elements: 6** | |
| ✓ Had vaginal sex?<br>✓ Performed oral sex?<br>✓ Received oral sex?<br>✓ Had anal sex?<br>✓ Other vaginal penetration? (ex: fingers, toys)<br>✓ Used vaginal lubricants? (ex: KY Jelly, Astroglide) | |
| Compared with the average American woman, how would you rate the amount of stress you have to deal with in your life right now? | Select one |
| o Much less stress than most people<br>o A bit less stress than most people<br>o About average stress<br>o A bit more stress than most people<br>o Much more stress than most people | |
| **The following data elements collect "Considering everything you have to deal with in your life, how much do you think the following are source of stress compared with other people?" with a scale of "Much Less; A Bit Less; About Average; A Bit More; Much More".**<br>**Subtotal data elements: 6** | |
| ✓ Money worries<br>✓ Worries about having a place to live<br>✓ Worries about my relationship with family or people close to me<br>✓ Worries about my health<br>✓ The burden of taking care of children, relatives or people close to me<br>✓ Worries about my work | |
| **The following data elements collect "In the last month, how often have you ___" with a scale of "Never; Almost Never; Sometimes; Fairly Often; Very Often".**<br>**Subtotal data elements: 10** | |
| ✓ Been upset because of something that happened unexpectedly?<br>✓ Felt that you were unable to control the important things in your life?<br>✓ Felt nervous and "stressed"?<br>✓ Felt confident about your ability to handle your personal problems?<br>✓ Felt that things were going your way?<br>✓ Found that you could not cope with all the things that you had to do?<br>✓ Been able to control irritations in your life?<br>✓ Felt that you were on top of things?<br>✓ Been angered because of things that were outside of your control?<br>✓ Felt difficulties were piling up so high that you could not overcome them? | |
| Since your last visit, have you experienced any of the following? | Check all that apply |
| o An abnormal amount of stress<br>o Trouble sleeping or falling asleep | |

| |
|---|
| ○ Depression<br>○ Anxiety<br>○ Little or no energy<br>○ Poor appetite<br>○ Trouble concentrating<br>○ Mood swings |

| | |
|---|---|
| How were you born? | Select one |
| ○ C-section<br>○ Vaginal delivery<br>○ Do not know | |
| Were you breast fed? | Yes/No/Not sure |
| Do you plan to breast feed? | Yes/No/Not sure |
| Since your last study visit, have there been any other changes you think we should know about? | Text |

## 6.4 Delivery and Discharge

The following data elements are collected from the Delivery and Discharge Q.
The total number of data fields is 43.

| **Data Element** | **Field Type** |
|---|---|
| When did you first start receiving prenatal care for this pregnancy? | Select one |
| ○ Before conception<br>○ 0-4 weeks after conception<br>○ 4 weeks to the end of the 1st trimester<br>○ During the 2nd trimester<br>○ During the 3rd trimester<br>○ I did not receive prenatal care<br>○ Not sure | |
| What was your due date? | Date |
| When was your baby (or babies) actually born? | Date |
| How long ago was your baby born? | Select one |
| ○ Less than 12 hours ago<br>○ 12-24 hours (1 day) ago<br>○ 24-48 hours (1 to 2 days) ago<br>○ More than 48 hours (2 days) ago<br>○ Not sure | |
| How was your baby delivered? *If you had twins or multiples, check all that apply.* | Select one/Check all that apply |
| ○ Vaginal delivery (not assisted)<br>○ Assisted vaginal delivery (forceps or vacuum)<br>○ Cesarean section (C-section) | |
| If delivered by Cesarean section, what was the reason? (If "How was your baby delivered?" = "Cesarean section") | Check all that apply |
| ○ Cervix stopped dilating (Failure to make progress in labor, e.g. baby is too large for pelvis)<br>○ Fetal distress (abnormal fetal heart rate)<br>○ Twins or triplets (or other multiple births)<br>○ Breech or fetal positioning that made delivery difficult (baby not positioned with head down) | |

| | |
|---|---|
| ○ Genital herpes outbreak<br>○ My own choice (elective)<br>○ Other<br>○ Not sure | |
| Other C-section reason spec (If "If delivered by Cesarean section, what was the reason?" = "Other") | Text |
| Were there any complications during your pregnancy or delivery? | Check all that apply |
| ○ Problems with placenta (e.g., Abruptio placentae or placenta previa)<br>○ Cervix had to be sewn shut (incompetent cervix)<br>○ Postpartum hemorrhage<br>○ Preeclampsia/eclampsia<br>○ I didn't have any problems<br>○ Not sure | |
| Was this pregnancy a multiple birth (twins, triplets, etc.)? | Yes/No |
| How many babies were delivered? (If "Was this pregnancy a multiple birth (twins, triplets, etc.)?" = Yes) | Number |
| What is the sex of your baby/babies? | Boy/Girl |
| After your baby (or babies) was born, was he/she put in an intensive care unit (ICU)? | Yes/No |
| After your baby was born, how long did he/she stay in the hospital? | Select one |
| ○ Less than 24 hours (less than 1 day)<br>○ 24 to 48 hours (1 to 2 days)<br>○ 3 days<br>○ 4 days<br>○ 5 days<br>○ 6 days or more<br>○ My baby was not born in the hospital<br>○ My baby is still in the hospital<br>○ My baby was stillborn<br>○ Not sure | |
| Did/Does your new baby/babies suffer from any of the following? | Check all that apply |
| ○ Jaundice (yellowing of the skin or whites of the eyes)<br>○ Breathing problems (e.g., respiratory distress syndrome, bronchopulmonary dysplasia)<br>○ Neurological problems (e.g., brain hemorrhage, intraventricular hemorrhage)<br>○ Bowel problems (e.g., necrotizing enterocolitis)<br>○ Infection (e.g., sepsis)<br>○ Feeding problems (e.g., needed gastric lavage for feedings)<br>○ None of the above<br>○ Not sure<br>○ Other | |
| Other complications spec (If "Did/Does your new baby/babies suffer from any of the following?" = "Other") | Text |
| Do you plan to breast feed? | Yes/No/Not sure |
| Even if your baby/babies stayed longer, when were YOU discharged from the hospital? | Select one |
| ○ I was discharged from the hospital<br>○ My doctors expect me to be discharged from the hospital soon<br>○ I am still in the hospital and my doctors expect me to have an extended stay | |

| | |
|---|---|
| ○ Not sure | |
| Discharge date (If "Even if your baby/babies stayed longer, when were YOU discharged from the hospital?" = "I was discharged from the hospital" or "My doctors expect me to be discharged from the hospital soon") | Date |
| How were you born? | Select one |
| ○ C-section<br>○ Vaginal delivery<br>○ Do not know | |
| Were you breast fed? | Yes/No/Not sure |
| How long? | Number |
| During the last 3 months before your new baby/babies was/were born, did you have any of the following? | Check all that apply |
| ○ I was physically injured<br>○ A close family member was very sick and had to go to the hospital<br>○ I was homeless<br>○ I argued with my husband/partner more than usual<br>○ I was separated or divorced from my husband/partner<br>○ Someone very close to me died<br>○ My husband/partner or I went to jail<br>○ I moved to a new address<br>○ My husband/partner said he didn't want me to be pregnant<br>○ My husband/partner lost their job<br>○ Someone very close to me had a problem with drinking or drugs<br>○ I had a lot of bills I couldn't pay<br>○ I lost my job even though I wanted to continue working<br>○ Not sure | |
| How would you describe your feelings about your most recent pregnancy? | Select one |
| ○ It was one of the happiest times of my life<br>○ It was generally a happy time with few exceptions<br>○ It wasn't any more or less difficult than before I was pregnant<br>○ It was generally a lot harder than before I was pregnant<br>○ It was one of the hardest times of my life<br>○ Other<br>○ Not sure | |
| Other feelings spec (If "How would you describe your feelings about your most recent pregnancy?" = "Other") | Text |
| **The following data elements collect "Considering everything you have to deal with in your life, how much do you think the following are sources of stress compared with other people?" with a scale of "Much Less; A Bit Less; About Average; A Bit More; Much More".**<br>**Subtotal data elements: 6** | |
| ✓ Money worries<br>✓ Worries about having a place to live<br>✓ Worries about my relationship with family or people close to me<br>✓ Worries about my health<br>✓ The burden of taking care of children, relatives or people close to me<br>✓ Worries about my work | |
| **The following data elements collect "In the last month, how often have you ___" with a scale of "Never; Almost Never; Sometimes; Fairly Often; Very Often".** | |

| **Subtotal data elements: 10** | |
|---|---|
| ✓ Been upset because of something that happened unexpectedly?<br>✓ Felt that you were unable to control the important things in your life?<br>✓ Felt nervous and "stressed"?<br>✓ Felt confident about your ability to handle your personal problems?<br>✓ Felt that things were going your way?<br>✓ Found that you could not cope with all the things that you had to do?<br>✓ Been able to control irritations in your life?<br>✓ Felt that you were on top of things?<br>✓ Been angered because of things that were outside of your control?<br>✓ Felt difficulties were piling up so high that you could not overcome them? | |
| Compared with the average American woman, how would you rate the amount of stress you have to deal with in your life right now? | Select one |
| ○ Much less stress than most people<br>○ A bit less stress than most people<br>○ About average stress<br>○ A bit more stress than most people<br>○ Much more stress than most people | |
| Since your last visit, have you experienced any of the following? | Check all that apply |
| ○ An abnormal amount of stress<br>○ Trouble sleeping or falling asleep<br>○ Depression<br>○ Anxiety<br>○ Little or no energy<br>○ Poor appetite<br>○ Trouble concentrating<br>○ Mood swings | |
| Since your last visit, have there been any other changes you think we should know about? | Text |

## 6.5 Prenatal Care

The following data elements are collected from the Follow Up Q – "Prenatal Care" section.
The total number of data fields is 65.

| **Data Element** | **Field Type** |
|---|---|
| Did you get prenatal care as early in your pregnancy as you wanted? | Yes/No |
| During your most recent pregnancy, have you had any of the following problems when you get prenatal care? | Check all that apply |
| ○ I couldn't get an appointment when I wanted one<br>○ I didn't have enough money or insurance to pay for my visits<br>○ I had no way to get to the clinic or doctor's office<br>○ I couldn't take time off from work<br>○ The doctor or my health plan would not start care as early as I wanted<br>○ I didn't have my Medicaid card<br>○ I had no one to take care of my children<br>○ I had too many other things going on<br>○ I didn't want anyone to know I was pregnant | |

| | |
|---|---|
| ○ Other<br>○ None of above | |
| Other problems spec (If "During your most recent pregnancy, have you had any of the following problems when you get prenatal care? = Yes) | Text |
| How was your delivery paid for? | Check all that apply |
| ○ Medicaid<br>○ Personal income (cash, check, or credit card)<br>○ Insurance through employer or spouse's employer<br>○ Government Subsidized Insurance<br>○ Independently purchased Insurance through Government Healthcare Market<br>○ Other | |
| Other payment method spec (If "How was your delivery paid for?" = Other) | Text |
| How was your prenatal care paid for? | Check all that apply |
| ○ Medicaid<br>○ Personal income (cash, check, or credit card)<br>○ Insurance through employer or spouse's employer<br>○ Government Subsidized Insurance<br>○ Independently purchased Insurance through Government Healthcare Market<br>○ Other | |
| Other payment method spec (If "How was your prenatal care paid for?" = Other) | Text |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the following things? | Check all that apply |
| ○ How smoking during pregnancy could affect your baby<br>○ Breastfeeding your baby<br>○ How drinking alcohol during pregnancy could affect your baby<br>○ Using a seat belt during your pregnancy<br>○ Medicines that are safe to take during your pregnancy<br>○ How using illegal drugs could affect your baby<br>○ Doing tests to screen for birth defects or diseases that run in your family<br>○ What to do if your labor starts early<br>○ How eating fish containing high levels of mercury could affect your baby<br>○ How much weight you should gain during your pregnancy<br>○ About "Baby blues" or postpartum depression<br>○ Taking a multivitamin or a prenatal vitamin during your pregnancy<br>○ None of above | |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the following questions? | Check all that apply |
| ○ How much alcohol you were drinking<br>○ If someone was hurting you emotionally or physically<br>○ If you were using illegal drugs (marijuana or hash, cocaine, crack, etc.)<br>○ If you wanted to be tested for HIV (the virus that causes AIDS)<br>○ If you planned to use birth control after your baby was born<br>○ None of above | |
| During your prenatal care visits, were you satisfied with any of the following? If you went to more than one place for prenatal care, answer for the place where you got MOST of your care. | Check all that apply |
| ○ The amount of time you had to wait after you arrived for your visits<br>○ The amount of time the doctor or nurse spent with you during your visits | |

| | |
|---|---|
| ○ The advice you got on how to take care of yourself<br>○ The understanding and respect that the staff showed toward you as a person<br>○ None of above | |
| At any time during your most recent pregnancy, did your regular prenatal care provider ask you to see a *specialist doctor* for help with any health problem(s)? | Yes/No |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about getting your blood tested for the disease called toxoplasmosis? | Yes/No |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the following things? | Check all that apply |
| ○ Not touching your mouth or eyes while handling raw meat<br>○ Cooking meat to "well done"<br>○ Washing hands and utensils after handling raw meat<br>○ Washing hands after contact with soil, sand, litter, or any other materials that may be contaminated with cat feces<br>○ Not feeding cats raw or undercooked meat<br>○ Not drinking/eating unpasteurized dairy products<br>○ None of above | |
| During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about the bacteria Group B Strep (*Beta Strep*) that mothers can pass to their newborns during birth? | Yes/No |
| At any time during your most recent pregnancy, did you get tested for the bacteria Group B Strep (Beta Strep)? | Yes/No |
| At any time during your most recent pregnancy or delivery, did you have a test for HIV (*the virus that causes AIDS*)? | Yes/No |
| When was your most recent HIV test during this pregnancy? (If "At any time during your most recent pregnancy or delivery, did you have a test for HIV (*the virus that causes AIDS*)?" = Yes) | Select one |
| ○ During the first 3 months of pregnancy<br>○ During the second 3 months of pregnancy<br>○ During the last 3 months of pregnancy<br>○ Unsure when, but during pregnancy and before delivery<br>○ At labor and delivery<br>○ After delivery but before hospital discharge | |
| Were you offered an HIV test during your most recent pregnancy or delivery? | Yes/No |
| Did you turn down the HIV test? (If "Were you offered an HIV test during your most recent pregnancy or delivery?" = Yes) | Yes/No |
| Why did you turn down the HIV test? (If "Did you turn down the HIV test?" = Yes) | Check all that apply |
| ○ I did not think I was at risk for HIV<br>○ I did not want people to think I was at risk for HIV<br>○ I was afraid of getting the result<br>○ I was tested before this pregnancy, and did not think I needed to be tested again<br>○ Other | |
| Other reasons spec (If "Why did you turn down the HIV test?" = "Other") | Text |
| Had you been tested for HIV *before* this pregnancy? | Yes/No |

| | |
|---|---|
| When were you tested *before* this pregnancy? (If "Had you been tested for HIV *before* this pregnancy?" = Yes) | Select one |
| ○ Less than 6 months before you got pregnant<br>○ 6 months to 1 year before you got pregnant<br>○ More than 1 year before you got pregnant | |
| At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker offer you a flu vaccination or tell you to get one? | Yes/No |
| Did you get a flu vaccination during your most recent pregnancy? | Yes/No |
| Have you ever had a flu vaccination when you were NOT pregnant? | Yes/No |
| What were your reasons for not getting a flu vaccination during your most recent pregnancy? (If "Did you get a flu vaccination during your most recent pregnancy?" = No) | Check all that apply |
| ○ My doctor didn't mention anything about a flu vaccination during my pregnancy<br>○ I was worried about side effects of the flu vaccination for me<br>○ I was worried that the flu vaccination might harm my baby<br>○ I wasn't pregnant during the flu season (November-February)<br>○ I was in my first trimester during the flu season (November-February)<br>○ I don't normally get a flu vaccination<br>○ Other | |
| Other reason spec for not getting a flu vaccination (If "What were your reasons for not getting a flu vaccination during your most recent pregnancy?" = "Other") | Text |
| In the last two months (or since your last study visit), have you had any of the following infections? | Check all that apply |
| ○ Bacterial Vaginosis (BV)<br>○ Beta (Group B) Streptococcus<br>○ Chicken Pox<br>○ Chlamydia<br>○ Cytomegalovirus (CMV)<br>○ Ear/Sinus Infection<br>○ Genital Warts<br>○ Genital Herpes<br>○ Gonorrhea<br>○ Fifth Disease<br>○ HIV/AIDS<br>○ HPV<br>○ Listeriosis<br>○ Pelvic Inflammatory disease<br>○ Syphilis<br>○ Trichomoniasis<br>○ Toxoplasmosis<br>○ Urinary Tract Infection<br>○ Vaginitis<br>○ Yeast Infection<br>○ Other | |
| Other infections spec (If "In the last two months (or since your last study visit), have you had any of the following infections?" = "Other") | Text |

| | |
|---|---|
| **The following data elements collect "In the last two months (or since your last study visit), have you taken any of the following antibiotics?" with options of "Currently taking; Recently taken in the last 2 months". The date of medication taken is also collected if either option is checked.**<br>**Subtotal data elements: 9 x 2 = 18** | |
| ✓ Cephalosporins (eg. Keflex, Cefzil, Suprax)<br>✓ Macrolides (eg. Azithromycin, Erythromycin)<br>✓ Metronidazole (eg. Flagyl)<br>✓ Nitrofurantoin (eg. Macrobid)<br>✓ Penicillin (eg. Amoxicillin, Ampicillin)<br>✓ Quinolones (eg. Cipro, Levaquin, Floxacin)<br>✓ Sulfa Antibiotics (Ex: Bactrim, Septra)<br>✓ Tetracyclines (Ex: Doxycycline, Minocycline)<br>✓ Other Antibiotics | |
| Other antibiotics spec (If "In the last two months (or since your last study visit), have you taken any of the following antibiotics?" = "Other Antibiotics") | Text |
| Since your last study visit, have you taken any of the following medications? | Check all that apply |
| o Doctor-prescribed yeast infection medication?<br>o Over-the-counter yeast infection medication (Ex: Monistat)<br>o Insulin?<br>o Oral steroids? | |
| Insulin spec (If "Since your last study visit, have you taken any of the following medications?" = "Insulin?") | Text |
| Oral steroids spec (If "Since your last study visit, have you taken any of the following medications?" = "Oral steroids?") | Text |
| Are you currently taking any other new medications, supplements, or pills? | Yes/No |
| How many new medications are you taking? (If "Are you currently taking any other new medications, supplements, or pills?" = Yes) | Number |
| New medications spec (If "How many new medications are you taking?" > 0) | Text |
| Are you currently sexually active? | Yes/No |
| **The following data elements collect "When was the last time you ___" with a scale of "Within the last 24 hours; 1-2 days ago; 3-7 days ago; 1-3 weeks ago; More than 1 month ago; More than 1 year ago or never".**<br>**Subtotal data elements: 6** | |
| ✓ Had vaginal sex?<br>✓ Performed oral sex?<br>✓ Received oral sex?<br>✓ Had anal sex?<br>✓ Other vaginal penetration? (ex: fingers, toys)<br>✓ Used vaginal lubricants? (ex: KY Jelly, Astroglide) | |
| Do you currently have abnormal vaginal discharge? | Yes/No/Not sure |
| Do you currently have bad-smelling vaginal odor? | Yes/No/Not sure |
| Do you currently have vaginal itching? | Yes/No/Not sure |

## 6.6 Home and Work Environment

The following data elements are collected from the Follow Up Q – "Home and Work Environment" section.

The total number of data fields is 64.

| Data Element | Field Type |
|---|---|
| How long have you lived in your current home? | Number |
| Which of the following best describes your home? | Select one |
| ○ House<br>○ House split into 2 apartments/flats<br>○ Building with 3 or more apartments/flats<br>○ Hotel/Motel<br>○ Migrant Camp<br>○ Trailer or mobile home<br>○ Other | |
| Other home description spec (If "Which of the following best describes your home" = "Other") | Text |
| What is the total number of rooms in your home (please include all rooms including separate kitchens, utility, separate toilets, etc.)? | Number |
| Enter the total number of people that live in your home (include all adults and children) | Number |
| Do you have electricity in your home? | Yes/No |
| What material is the majority of the floor or floor covering of your home made of? | Select one |
| ○ Carpet/rug<br>○ Wood<br>○ Cement or Firme<br>○ Tile<br>○ Soil<br>○ Other | |
| Other floor material spec (If "What material is the majority of the floor or floor covering of your home made of?" = "Other") | Text |
| What is your roof made of? | Select one |
| ○ Asphalt Shingles<br>○ Tile<br>○ Concrete<br>○ Wood<br>○ Aluminum<br>○ Natural Resources (e.g. straw)<br>○ Scavenged Resources (e.g. cardboard)<br>○ Other | |
| Other roof material spec (If "What is your roof made of?" = "Other") | Text |
| Does the roof of your house leak? | Yes/No |
| What type of sanitary service does your home have? | Select one |
| ○ Toilet with a water connection<br>○ Toilet without a water connection<br>○ Outhouse<br>○ No sanitary service | |
| Do you have a stove/oven in your home? | Yes/No |
| What do you usually use to heat the stove/oven in your home? (If "Do you have a stove/oven in your home" = Yes) | Select one |

| | |
|---|---|
| ○ Gas<br>○ Electricity<br>○ Wood<br>○ Charcoal<br>○ Kerosene<br>○ Crop waste (e.g. compost)<br>○ Oil<br>○ Other | |
| Other heat source spec (If "What do you usually use to heat the stove/oven in your home?" = "Other") | Text |
| Do you sleep in the same room you cook in? | Yes/No |
| Do you heat your home? | Yes/No |
| What do you usually use to heat your home? (If "Do you heat your home" = Yes) | Yes/No |
| ○ Gas<br>○ Electricity<br>○ Wood<br>○ Charcoal<br>○ Kerosene<br>○ Crop waste (e.g. compost)<br>○ Oil<br>○ Other | |
| Other heat source spec (If "What do you usually use to heat your home?" = "Other") | Text |
| Does your kitchen get smoky when you cook or heat it? | Select one |
| ○ Not smoky<br>○ A little smoky<br>○ Pretty smoky<br>○ Very smoky (eyes and/or breathing affected) | |
| Do you get water from a tap in or around your home? | Yes/No |
| What is your source of drinking water? (If "Do you get water from a tap in or around your home?" = No) | Select one |
| ○ Communal tap away from your home<br>○ Bottled water<br>○ Rain collection<br>○ River<br>○ Pond<br>○ Well<br>○ Don't know | |
| Do you boil your water before drinking it? | Yes/No |
| How often do you or someone else usually sweep, mop, or vacuum your home? | Select one |
| ○ Never<br>○ Less than once a month<br>○ 1-3 times a month<br>○ 1-3 times a week<br>○ 4-6 times a week<br>○ Daily<br>○ Once a week | |

| | |
|---|---|
| Since you became pregnant, have you ever seen any mold or mildew on walls or other surfaces (other than food) inside your home? | Yes/No |
| Since you became pregnant, have you ever seen any water damage in your home, this could be from broken pipes, a leaky roof or floods? (*e.g. water stains on the ceiling or walls, rotting wood or plaster)* | Yes/No |
| Have you seen, or have you been aware of any of the following inside your home: | Check all that apply |
| ○ Options:<br>○ Mice or Rats / Cockroaches / None | |
| How many cats and dogs do you have at home? | Number |
| Since you became pregnant, have pesticides been applied in your home? | Yes/No |
| Since you became pregnant, have pesticides been applied outside your home? | Yes/No |
| Have you personally applied any of these pesticides? | Yes/No |
| Has anyone living with you worked on a farm or in a green house? | Yes/No |
| How often does the air in the area where you live make it difficult to breathe? | Select one |
| ○ Options:<br>○ Never / Sometimes / Frequently / Always | |
| How often does the air in the area where you live make your eyes sting? | Select one |
| ○ Options:<br>○ Never / Sometimes / Frequently / Always | |
| Do you live within 5 minutes' walk of an agricultural field? | Yes/No |
| Do you live within 5 minutes' walk of a road that is used by large trucks? | Yes/No |
| Do you live within 5 minutes' walk of a site where chemicals are known to be dumped? | Yes/No |
| Do you live within 5 minutes' walk of a factory that emits fumes or smoke? | Yes/No |
| **The following data elements collect "within 5 minutes' walking distance of home ___" with a scale of "Not a problem, Some problem, A big problem".**<br>**Subtotal data elements: 8** | |
| ✓ Loud music or other noise (constructions, trains, etc.)<br>✓ Rubbish/Trash and litter on the streets<br>✓ People using or selling drugs<br>✓ Crime, such as robberies or assaults<br>✓ No safe place for children to play<br>✓ Not safe to walk alone at night<br>✓ Stray dogs<br>✓ Dogs barking at night | |
| Since you became pregnant, have you worked formally inside or outside of your home? | Yes/No |
| How many hours per week have you worked? | Number |
| Does/Did this include the evening or night shift (starting after 2 PM)? | Yes/No |
| Do/Did you rotate among different shifts for this job? | Yes/No |
| In what position have you spent most of your working day? | Select one |
| ○ Options:<br>○ Sitting / Standing / Walking / Other | |

| Since becoming pregnant, have you worked in any of these businesses or industries? | Check all that apply |
|---|---|
| ○ Janitor or house cleaning<br>○ Dry cleaning<br>○ Construction<br>○ Farm or plant nursery<br>○ Chemical plant<br>○ Plastic products or manufacturing<br>○ Hair salon<br>○ Car or truck repair<br>○ Healthcare or dentistry<br>○ Landscaping or grounds keeping<br>○ Hazardous waste<br>○ Semiconductor manufacturing<br>○ Nail salon<br>○ Gas station<br>○ Science laboratory<br>○ Printing company<br>○ Electronics manufacturing<br>○ Other manufacturing | |
| Other manufacturing spec (If "Since becoming pregnant, have you worked in any of these businesses or industries." = "Other manufacturing") | Text |
| Since becoming pregnant, have you done any of these activities in your work? | Check all that apply |
| ○ Use dyes (hair or textile)<br>○ Make or spray fungicides (chemicals which kill molds)<br>○ Use strong acids or bases<br>○ Mix or apply paints or lacquers<br>○ Apply varnish, finish or seals<br>○ Plastic products or manufacturing<br>○ Use janitorial/cleaning chemicals<br>○ Use other chemicals<br>○ Strip or thin paint<br>○ Make or spray pesticides (chemicals which kill insects)<br>○ Apply glues or adhesives<br>○ Degrease tools, machines or electronics<br>○ Weld<br>○ Use X-ray or radioactive substances<br>○ Use lead or other metals<br>○ Use dry cleaning chemicals<br>○ Make or spray herbicides (chemicals which kill weeds)<br>○ Apply artificial nails<br>○ Handle or make pharmaceuticals<br>○ Work with laboratory chemicals<br>○ Work with anesthetic gases or sterilizers<br>○ Use solvents or degreasers (for cleaning sticky/greasy things) | |
| Other chemicals spec (If "Since becoming pregnant, have you done any of these activities in your work?" = "Use other chemicals") | Text |

| Since becoming pregnant, has this working environment given you any of the following symptoms? | Check all that apply |
|---|---|
| ○ Headache<br>○ Coughing or sore throat<br>○ Nausea<br>○ Itchy or teary eyes<br>○ Hives, rash, or itchy skin<br>○ Vomiting<br>○ Sneezing or bloody nose<br>○ Dizziness | |
| **The following data elements are collected for working environments and with a scale of "Often; Sometimes; Never".**<br>**Subtotal data elements: 9** | |
| ✓ Very cold (less than 60F/15C)<br>✓ Very hot (greater than 80F/27C)<br>✓ Loud (can't hear neighbors speak)<br>✓ Dusty, such as from drilling or grinding<br>✓ Smelling strongly from plastic or resin fumes<br>✓ Smelling strongly from lead or other metal fumes<br>✓ Smelling strongly from solvents<br>✓ Poorly ventilated<br>✓ Chronically water damaged or moldy | |

## 6.7 Most Recent Pregnancy and After Delivery

The following data elements are collected from the Follow Up Q – "Most Recent Pregnancy" and "After Delivery" sections.
The total number of data fields is 67.

| **Data Element** | **Field Type** |
|---|---|
| **Section: Most recent pregnancy** | |
| Did you have any of these problems during your most recent pregnancy? | Check all that apply |
| ○ I was hurt in a car accident<br>○ Severe nausea, vomiting, or dehydration<br>○ Problems with the placenta (i.e. abruptio placentae or placenta previa)<br>○ High blood pressure, hypertension (including pregnancy-induced hypertension [PIH], preeclampsia, or toxemia)<br>○ Vaginal bleeding<br>○ Cervix had to be sewn shut (incompetent cervix)<br>○ Labor pains more than 3 weeks before my baby was due (preterm or early labor)<br>○ Water broke more than 3 weeks before my baby was due (premature rupture of membranes [PROM])<br>○ Kidney or bladder (urinary tract) infection<br>○ I had to have a blood transfusion<br>○ High blood sugar (diabetes) that started during this pregnancy<br>○ None | |
| Did you do any of the following things because of these problems? | Check all that apply |
| ○ I went to the hospital or emergency room and stayed less than 1 day<br>○ I stayed in bed at home more than 2 days because of my doctor's or nurse's advice<br>○ I went to the hospital and stayed 1 to 7 days | |

| | |
|---|---|
| ○ I went to the hospital and stayed more than 7 days<br>○ None | |
| At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker tell you to stay in bed for at least 1 week? | Yes/No |
| How many weeks pregnant were you when you were told to stay in bed? (If "At any time during your most recent pregnancy, did a doctor, nurse, or other health care worker tell you to stay in bed for at least 1 week?" = Yes) | Number |
| How often were you able to follow your provider's instruction to stay in bed? | Select one |
| ○ Options:<br>○ Always / Often / Sometimes / Rarely / Never | |
| What types of support would have helped you to stay in bed for the recommended time? | Check all that apply |
| ○ Help with child care<br>○ Help with housework<br>○ Knowing I wouldn't lose my job<br>○ Money to make up for not working<br>○ Other<br>○ NONE | |
| Other support spec (If "What types of support would have helped you to stay in bed for the recommended time?" = "Other") | Text |
| During the last 3 months before your new baby was born, did you have any of the following? | Check all that apply |
| ○ I was in a physical fight<br>○ A close family member was very sick and had to go to the hospital<br>○ I was homeless<br>○ I argued with my husband or partner more than usual<br>○ I got separated or divorced from my husband or partner<br>○ Someone very close to me died<br>○ My husband or partner or I went to jail<br>○ I moved to a new address<br>○ My husband or partner said he didn't want me to be pregnant<br>○ My husband or partner lost his job<br>○ Someone very close to me had a bad problem with drinking or drugs<br>○ I had a lot of bills I couldn't pay<br>○ I lost my job even though I wanted to go on working<br>○ NONE | |
| During the last 3 months of your most recent pregnancy, were you physically hurt in any way by your husband or partner? | Yes/No |
| How would you describe your feelings about your most recent pregnancy? | Select one |
| ○ It was one of the happiest times of my life<br>○ It was generally a happy time with few exceptions<br>○ It wasn't any more or less difficult than before I was pregnant<br>○ It was generally a lot harder than before I was pregnant<br>○ It was one of the hardest times of my life<br>○ Other<br>○ Not sure | |

| | |
|---|---|
| Other feelings spec (If "How would you describe your feelings about your most recent pregnancy?" = "Other") | Text |
| **The following data elements collect "Considering everything you have to deal with in your life, how much do you think the following are source of stress compared with other people?" with a scale of "Much Less; A Bit Less; About Average; A Bit More; Much More".**<br>**Subtotal data elements: 6** | |
| ✓ Money worries<br>✓ Worries about having a place to live<br>✓ Worries about my relationship with family or people close to me<br>✓ Worries about my health<br>✓ The burden of taking care of children, relatives or people close to me<br>✓ Worries about my work | |
| **The following data elements collect "In the last month, how often have you ___" with a scale of "Never; Almost Never; Sometimes; Fairly Often; Very Often".**<br>**Subtotal data elements: 10** | |
| ✓ Been upset because of something that happened unexpectedly?<br>✓ Felt that you were unable to control the important things in your life?<br>✓ Felt nervous and "stressed"?<br>✓ Felt confident about your ability to handle your personal problems?<br>✓ Felt that things were going your way?<br>✓ Found that you could not cope with all the things that you had to do?<br>✓ Been able to control irritations in your life?<br>✓ Felt that you were on top of things?<br>✓ Been angered because of things that were outside of your control?<br>✓ Felt difficulties were piling up so high that you could not overcome them? | |
| Compared with the average American woman, how would you rate the amount of stress you have to deal with in your life right now? | Select one |
| o Much less stress than most people<br>o A bit less stress than most people<br>o About average stress<br>o A bit more stress than most people<br>o Much more stress than most people | |
| **The following data elements collect "Have you noticed, starting within about 6 months of having a baby, any of the following" with options of "Yes/No".**<br>**Subtotal data elements: 13** | |
| ✓ Feeling restless or irritable.<br>✓ Feeling sad, depressed or crying a lot.<br>✓ Having no energy.<br>✓ Having headaches, chest pains, heart palpitations (the heart beating fast and feeling like it is skipping beats), numbness, or hyperventilation (fast and shallow breathing).<br>✓ Not being able to sleep or being very tired, or both.<br>✓ Not being able to eat and weight loss.<br>✓ Overeating and weight gain.<br>✓ Trouble focusing, remembering, or making decisions.<br>✓ Being overly worried about the baby.<br>✓ Not having any interest in the baby.<br>✓ Feeling worthless and guilty.<br>✓ Being afraid of hurting the baby or yourself. | |

| | |
|---|---|
| ✓ No interest or pleasure in activities, including sex. | |
| Since your last study visit, how many cigarettes have you smoked in an average day? | Number |
| Since your last study visit, how many alcoholic drinks have you had in an average week? | Number |
| Since your last study visit, how often have you been exposed to second hand smoke? | Select one |
| ○ Options:<br>○ Every day / Almost every day / Rarely / Never | |
| **Section: After Delivery** | |
| After your baby was born, was he or she put in an intensive care unit? | Yes/No |
| After your baby was born, how long did he or she stay in the hospital? | Select one |
| ○ Less than 24 hours (less than 1 day)<br>○ 24 to 48 hours (1 to 2 days)<br>○ 3 days<br>○ 4 days<br>○ 5 days<br>○ 6 days or more<br>○ My baby was not born in the hospital<br>○ My baby is still in the hospital<br>○ My baby was stillborn<br>○ Not sure | |
| Is your baby alive now? | Yes/No |
| **The following data elements are collected ONLY when "Is your baby alive now" is answered "Yes".** | |
| Is your baby living with you now? | Yes/No |
| At the hospital where your new baby was born, did you have any of the following? | Check all that apply |
| ○ Hospital staff gave me information about breastfeeding<br>○ My baby stayed in the same room with me at the hospital<br>○ I breastfed my baby in the hospital<br>○ I breastfed my baby in the first hour after my baby was born<br>○ Hospital staff helped me learn how to breastfeed<br>○ My baby was fed only breast milk at the hospital<br>○ Hospital staff told me to breastfeed whenever my baby wanted<br>○ The hospital gave me a gift pack with formula<br>○ The hospital gave me a telephone number to call for help with breastfeeding<br>○ My baby used a pacifier in the hospital<br>○ My baby wasn't born in a hospital<br>○ None of above | |
| About how many hours a day, on average, is your new baby in the same room with someone who is smoking? | Number |
| How do you most often lay your baby down to sleep now? | Select one |
| ○ On his or her side<br>○ On his or her back<br>○ On his or her stomach | |
| How often does your new baby sleep in the same bed with you or anyone else? | Select one |

| | |
|---|---|
| ○ Options:<br>○ Always / Often / Sometimes / Rarely / Never | |
| Was your new baby seen by a doctor, nurse, or other health care worker during the first week after he or she left the hospital? | Yes/No |
| Was your new baby seen at home or at a health care facility during the first week after leaving the hospital? | Check all that apply |
| ○ At home<br>○ At a doctor's office, clinic, or other health care facility<br>○ My baby didn't have a medical visit during the first week after leaving the hospital. | |
| Did/Does your new baby/babies suffer from any of the following? | Check all that apply |
| ○ Jaundice (yellowing of the skin or whites of the eyes)<br>○ Breathing problems (e.g., respiratory distress syndrome, bronchopulmonary dysplasia)<br>○ Neurological problems (e.g., brain hemorrhage, intraventricular hemorrhage)<br>○ Bowel problems (e.g., necrotizing enterocolitis)<br>○ Infection (e.g., sepsis)<br>○ Feeding problems (e.g., needed gastric lavage for feedings)<br>○ None of the above<br>○ Not sure<br>○ Other | |
| Other baby complications spec (If "Did/Does your new baby/babies suffer from any of the following?" = "Other") | Text |
| Has your new baby had a well-baby checkup? | Select one |
| ○ Options:<br>○ Yes / No / My baby is less than 2 months old | |
| Where have you taken your new baby when he or she was sick and needed care? | Check all that apply |
| ○ Hospital clinic<br>○ Health department clinic<br>○ Hospital emergency room<br>○ Private doctor's office<br>○ Basic Health Plan<br>○ Other | |
| Other sick baby care spec (If "Where have you taken your new baby when he or she was sick and needed care?" = "Other") | Text |
| Has your new baby gone for care as many times as you wanted when he or she was sick? | Yes/No |
| Do you have health insurance or Medicaid for your new baby? | Yes/No |
| What type of insurance is your new baby covered by? (If "Do you have health insurance or Medicaid for your new baby?" = Yes) | Check all that apply |
| ○ Medicaid<br>○ Personal income (cash, check, or credit card)<br>○ Insurance through employer or spouse's employer<br>○ Government Subsidized Insurance<br>○ Independently purchased Insurance through Government Healthcare Market<br>○ Other | |
| Other insurance spec (If "What type of insurance is your new baby covered by?" = "Other") | Text |

| **Alive baby data collections stop here.** | |
|---|---|
| Since your new baby was born, have you had any medical problem that caused you to go to the hospital and stay overnight? | Yes/No |
| When was the FIRST time you had to go to the hospital and stay overnight after you had your new baby? (If "Since your new baby was born, have you had any medical problem that caused you to go to the hospital and stay overnight?" = Yes) | Date |
| What kind of medical problems caused you to go to the hospital? (If "Since your new baby was born, have you had any medical problem that caused you to go to the hospital and stay overnight?" = Yes) | Check all that apply |
| ○ Options:<br>○ Vaginal bleeding / Fever or infection / Other | |
| Other medical problems spec (If "What kind of medical problems caused you to go to the hospital?" = "Other") | Text |