UNIVERSITY OF MINNESOTA

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BAYLOR/TEXAS MEDICAL CENTER, HOUSTON CHILDREN'S HOSPITAL, DENVER CHILDREN'S HOSPITAL OF COLUMBUS CHILDREN'S HOSPITAL OF LOS ANGELES CHILDREN'S HOSPITAL & MEDICAL CENTER, SEATTLE CHILDREN'S HOSPITAL OF PHILADELPHIA CHILDREN'S HOSPITAL OF PITTSBURGH CHILDREN'S MEDICAL CENTER, DALLAS ROSWELL PARK, BUFFALO HOSPITAL FOR SICK CHILDREN, TORONTO

Long-Term Follow-Up Study

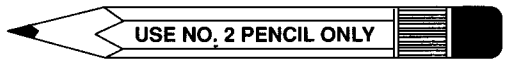
Pregnancy Questionnaire

Person completing this questionnaire is _____
(Please print your full name)

Today's date _____
(month/day/year)

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. **Use the *No. 2 pencil enclosed* (Please do *not* use pen).**



2. **Completely darken your answers, that is, fill in the full circle.**

CORRECT	INCORRECT
Ⓐ Ⓑ Ⓒ ●	⊗ ✓ ◉ ◔

Written responses must stay within the boxes provided.

CORRECT	INCORRECT
grape	grape

3. **Make no stray marks of any kind. Other than your responses, please keep the form as clean as possible. Erase cleanly any answer you wish to change. Do not use "white-out".**

00472

PLEASE DO NOT MARK IN THIS AREA

Please complete a column in this questionnaire for each time that you were pregnant (including any miscarriages or induced abortions). It is important that you answer all the questions for each individual pregnancy, before answering the questions for the next pregnancy.

1st Pregnancy

A 1. At the time of this pregnancy, what was your age and the father's age?

a. Your age	b. Father's age
0 0	0 0
1 1	1 1
2 2	2 2
3 3	3 3
4 4	4 4
5 5	5 5
6 6	6 6
7 7	7 7
8 8	8 8
9 9	9 9

Please leave this space blank.

A 2. Was this a planned pregnancy? ○ Yes ○ No

A 3. If this was a planned pregnancy, how many months did you try to get pregnant before the pregnancy?

Months:

A 4a. In the year prior to the start of this pregnancy, did you see a doctor because of difficulties becoming pregnant? ○ Yes ○ No

4b. Did the father see a doctor because of difficulties in your becoming pregnant? ○ Yes ○ No

A 5a. In the year prior to this pregnancy, did you take any medications to aid in getting pregnant? (Fertility drugs such as Clomid) ○ Yes ○ No

If yes, specify medication:

5b. Did the father take any medications to aid in your getting pregnant? ○ Yes ○ No

If yes, specify medication:

A 6. Was this pregnancy the result of in-vitro fertilization (test tube baby, or where the egg is fertilized outside the mother and then re-implanted)? ○ Yes ○ No

A 7. Were there any other things done to aid you in becoming pregnant, (besides taking medication or in-vitro fertilization)? ○ Yes ○ No

If yes, specify:

A 8a. During the year prior to the pregnancy, did you receive chemotherapy or radiation therapy for the treatment of a tumor, cancer, leukemia, or similar illness? ○ Yes ○ No

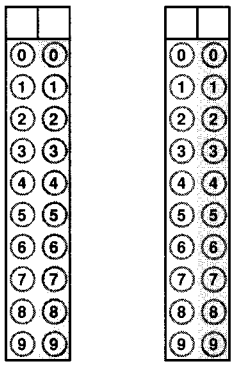
If yes, specify treatment:

Continue on page 4 with Pregnancy 1 before going on to Pregnancy 2

2nd Pregnancy

a. Your age

b. Father's age



○ Yes ○ No

Months:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

If yes, specify:

○ Yes ○ No

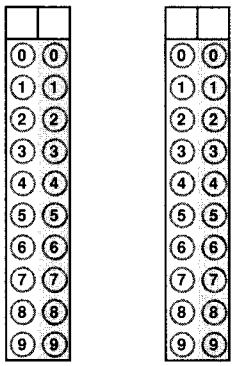
If yes, specify treatment:

Continue on page 4

3rd Pregnancy

a. Your age

b. Father's age



○ Yes ○ No

Months:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

If yes, specify:

○ Yes ○ No

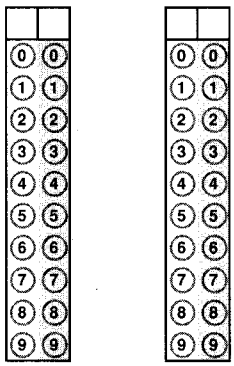
If yes, specify treatment:

Continue on page 4

4th Pregnancy

a. Your age

b. Father's age



○ Yes ○ No

Months:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

If yes, specify:

○ Yes ○ No

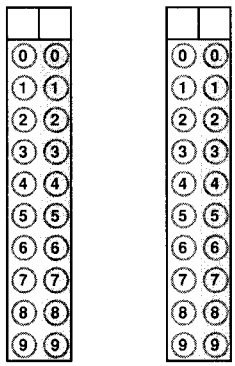
If yes, specify treatment:

Continue on page 4

5th Pregnancy

a. Your age

b. Father's age



○ Yes ○ No

Months:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

If yes, specify:

○ Yes ○ No

If yes, specify treatment:

Continue on page 4

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PLEASE DO NOT MARK IN THIS AREA

A 8b. During the year prior to the start of the pregnancy, did the father receive chemotherapy or radiation therapy for the treatment of a tumor, cancer, leukemia, or similar illness?

1st Pregnancy

○ Yes ○ No

If yes, specify treatment:

B 1. Did you have any of the following conditions during this pregnancy?

High blood pressure	○ Yes ○ No
Toxemia of pregnancy	○ Yes ○ No
Anemia	○ Yes ○ No
Threatened miscarriage	○ Yes ○ No
Diabetes	○ Yes ○ No
Excessive vomiting (Hyperemesis gravidarum)	○ Yes ○ No
Bladder or other infections for which you took antibiotics	○ Yes ○ No
Heart failure	○ Yes ○ No
Any other illness or complication of the pregnancy?	○ Yes ○ No

If yes, specify:

B 2. During this pregnancy, did you smoke cigarettes?

○ Yes ○ No

If yes, please indicate which months during this pregnancy that you smoked.

○ Months 1-3
○ Months 4-6
○ Months 7-9

During the time you smoked, on average, how many cigarettes per day did you smoke?

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Cigarettes per day

B 3. During this pregnancy, did you drink alcoholic beverages?

○ Yes ○ No

If yes, please indicate which months during this pregnancy that you drank.

○ Months 1-3
○ Months 4-6
○ Months 7-9

If you drank, approximately how many drinks per month did you have?

○ Less than 1 drink
○ 1-4 drinks
○ 5-10 drinks
○ 11-30 drinks
○ More than 30 drinks

Continue on page 6 with Pregnancy 1 before going on to Pregnancy 2

2nd Pregnancy

◯ Yes ◯ No

If yes, specify treatment:

◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No

If yes, specify:

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

Cigarettes per day

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

◯ Less than 1 drink
◯ 1-4 drinks
◯ 5-10 drinks
◯ 11-30 drinks
◯ More than 30 drinks

Continue on page 6

3rd Pregnancy

◯ Yes ◯ No

If yes, specify treatment:

◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No

If yes, specify:

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

Cigarettes per day

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

◯ Less than 1 drink
◯ 1-4 drinks
◯ 5-10 drinks
◯ 11-30 drinks
◯ More than 30 drinks

Continue on page 6

4th Pregnancy

◯ Yes ◯ No

If yes, specify treatment:

◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No

If yes, specify:

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

Cigarettes per day

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

◯ Less than 1 drink
◯ 1-4 drinks
◯ 5-10 drinks
◯ 11-30 drinks
◯ More than 30 drinks

Continue on page 6

5th Pregnancy

◯ Yes ◯ No

If yes, specify treatment:

◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No
◯ Yes ◯ No

If yes, specify:

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

Cigarettes per day

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

◯ Yes ◯ No

◯ Months 1-3
◯ Months 4-6
◯ Months 7-9

◯ Less than 1 drink
◯ 1-4 drinks
◯ 5-10 drinks
◯ 11-30 drinks
◯ More than 30 drinks

Continue on page 6

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PLEASE DO NOT MARK IN THIS AREA

1st Pregnancy

B 4. Did you take supplemental vitamins during the pregnancy? ○ Yes ○ No

B 5. At any time during the pregnancy, did a doctor prescribe medicines for you to take? ○ Yes ○ No

If yes, were these:

antibiotics	○ Yes	○ No
medicines for high blood pressure	○ Yes	○ No
supplemental iron	○ Yes	○ No
medicine for nausea (morning sickness)	○ Yes	○ No
heart medications	○ Yes	○ No
other medicines	○ Yes	○ No

If yes, specify medication:

B 6. Did you receive chemotherapy or radiation therapy for a tumor, cancer, leukemia, or other illness during the time you were pregnant? ○ Yes ○ No

B 7. Did you ever use marijuana, cocaine, or other recreational drugs during the pregnancy? ○ Yes ○ No

B 8. Was this pregnancy complicated by premature labor? ○ Yes ○ No

If yes, what was done to stop the labor?

nothing	○ Yes	○ No
bed rest	○ Yes	○ No
medications	○ Yes	○ No

B 9. How did this pregnancy end?

Induced (elective) abortion	○
Miscarriage (loss of child before 20 weeks)	○
Stillbirth (loss of child at 20 weeks or later)	○
Live birth	○

B 10. What was the date of birth of the baby or the date the pregnancy ended?

Mo.	Day	Year
0 0 1 1 2 3 4 5 6 7 8 9	0 0 1 1 2 3 4 5 6 7 8 9	0 0 1 1 2 3 4 5 6 7 8 9

If this pregnancy ended as a miscarriage or an induced abortion, go back to page 2, and answer questions for the next pregnancy.

If Pregnancy 1 was a live birth or a stillbirth, continue on page 8 before going on to Pregnancy 2

2nd Pregnancy

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

○
○
○
○

Mo.	Day	Year
0 0	0 0	0 0
1 1	1 1	1 1
2	2 2	2 2
3	3 3	3 3
4	4	4 4
5	5	5 5
6	6	6 6
7	7	7 7
8	8	8 8
9	9	9 9

If Pregnancy 2 was a live birth or a stillbirth, continue on page 8 before going on to Pregnancy 3

3rd Pregnancy

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

○
○
○
○

Mo.	Day	Year
0 0	0 0	0 0
1 1	1 1	1 1
2	2 2	2 2
3	3 3	3 3
4	4	4 4
5	5	5 5
6	6	6 6
7	7	7 7
8	8	8 8
9	9	9 9

If Pregnancy 3 was a live birth or a stillbirth, continue on page 8 before going on to Pregnancy 4

4th Pregnancy

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

○
○
○
○

Mo.	Day	Year
0 0	0 0	0 0
1 1	1 1	1 1
2	2 2	2 2
3	3 3	3 3
4	4	4 4
5	5	5 5
6	6	6 6
7	7	7 7
8	8	8 8
9	9	9 9

If Pregnancy 4 was a live birth or a stillbirth, continue on page 8 before going on to Pregnancy 5

5th Pregnancy

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, specify medication:

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

○
○
○
○

Mo.	Day	Year
0 0	0 0	0 0
1 1	1 1	1 1
2	2 2	2 2
3	3 3	3 3
4	4	4 4
5	5	5 5
6	6	6 6
7	7	7 7
8	8	8 8
9	9	9 9

If Pregnancy 5 was a live birth or stillbirth, continue on page 8

These questions refer to the labor and delivery of pregnancies that resulted in a live birth or a stillbirth. If this pregnancy resulted in a miscarriage or an abortion, please leave the remaining columns for this pregnancy blank, and go to page 2 for the next pregnancy.

1st Pregnancy

C 1. If this pregnancy was a live birth or a stillbirth, how many weeks pregnant were you at the time of delivery?

Weeks

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

C 2. If this pregnancy was a live birth or a stillbirth, did labor begin by itself or was it induced?

○ Itself ○ Induced

C 3. If induced, what was used to induce the labor?

Artificial rupture of membranes (Doctor or nurse "broke your water")	○ Yes ○ No
Drugs, such as Pitocin to start labor	○ Yes ○ No

C 4. How many hours did the labor last? (Time from the beginning of regular contractions until birth. If a scheduled C-Section and no labor, please enter 000.)

Hours

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

C 5. During labor, did you develop any of the following conditions?

high blood pressure requiring medicines	○ Yes ○ No
heart failure	○ Yes ○ No

C 6. If this pregnancy was a live birth or a stillbirth, how was the baby delivered?

normal vaginal delivery	○ Yes ○ No
elective C-section (planned in advance)	○ Yes ○ No
unplanned C-section	○ Yes ○ No

If yes, give reason:

Continue on page 10 with Pregnancy 1 before going on to Pregnancy 2

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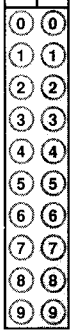
2nd Pregnancy

Weeks



○ Itself ○ Induced

○ Yes ○ No
○ Yes ○ No

Hours

○ Yes ○ No
○ Yes ○ No

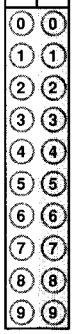
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, give reason:

Continue on page 10

3rd Pregnancy

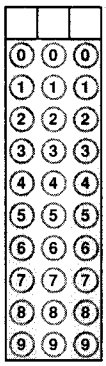
Weeks



○ Itself ○ Induced

○ Yes ○ No
○ Yes ○ No

Hours



○ Yes ○ No
○ Yes ○ No

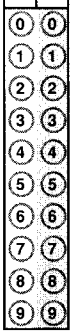
○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, give reason:

Continue on page 10

4th Pregnancy

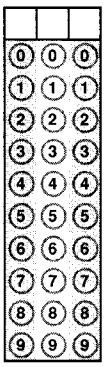
Weeks



○ Itself ○ Induced

○ Yes ○ No
○ Yes ○ No

Hours



○ Yes ○ No
○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, give reason:

Continue on page 10

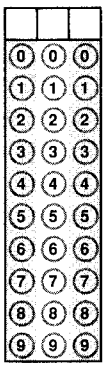
5th Pregnancy

Weeks

○ Itself ○ Induced

○ Yes ○ No
○ Yes ○ No

Hours



○ Yes ○ No
○ Yes ○ No

○ Yes ○ No
○ Yes ○ No
○ Yes ○ No

If yes, give reason:

Continue on page 10

1st Pregnancy

D 1. Was this a singleton (one child) or multiple (twins or more) birth?

○ One child
○ Twins or more

D 2. What is the sex of this child?

○ Male ○ Female

D 3. How much did he/she weigh at birth?
(If twins or more, please write in first names and weights on page 12.)

lbs oz

These questions only apply to live births. If this pregnancy was a stillbirth, please leave the remainder of this column for this pregnancy blank in this section and return to page 2.

D 4. If this pregnancy was a live birth, what is the first name of this child?
(If twins or other multiple birth, fill in names of all children.)

Name of child (children):

D 5. After the birth, did this baby go

to a regular newborn nursery? ○ Yes ○ No ○ Don't know

to a special, high risk nursery or neonatal intensive care unit? ○ Yes ○ No ○ Don't know

D 6. Did this child leave the hospital with you? ○ Yes ○ No

D 7. How would you characterize the general health of this child?

○ Excellent ○ Fair
○ Good ○ Poor
○ Unknown

D 8. Has this child ever been hospitalized or had a serious illness? ○ Yes ○ No ○ Don't know

If yes, specify:

D 9. Has this child ever had surgery? ○ Yes ○ No ○ Don't know

If yes, specify surgery:

Please go on to the next pregnancy, if any, by returning to page 2 and 3 of this booklet. If more than 5 pregnancies, please continue in next booklet.

PLEASE DO NOT MARK IN THIS AREA

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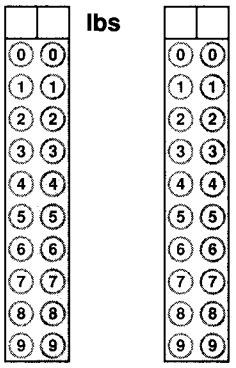
2nd Pregnancy

○ One child
○ Twins or more

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No

○ Excellent ○ Fair
○ Good ○ Poor
○ Unknown

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

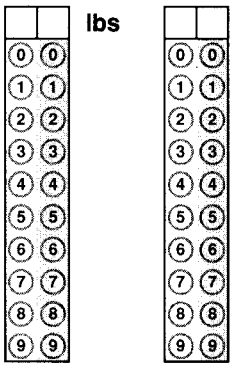
If yes, specify surgery:

3rd Pregnancy

○ One child
○ Twins or more

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No

○ Excellent ○ Fair
○ Good ○ Poor
○ Unknown

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

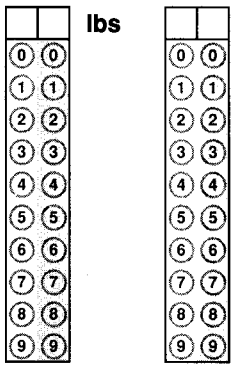
If yes, specify surgery:

4th Pregnancy

○ One child
○ Twins or more

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No

○ Excellent ○ Fair
○ Good ○ Poor
○ Unknown

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

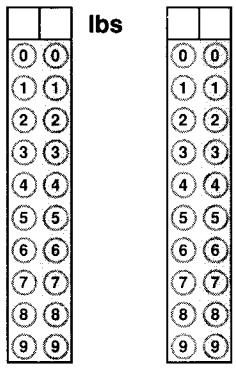
If yes, specify surgery:

5th Pregnancy

○ One child
○ Twins or more

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No

○ Excellent ○ Fair
○ Good ○ Poor
○ Unknown

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

If yes, specify surgery:

USE THIS SPACE FOR INFORMATION ABOUT MULTIPLE BIRTHS:

USE THIS SPACE FOR OTHER COMMENTS:

After completing this questionnaire, please return by using the enclosed envelope, and mail to:

Leslie L. Robison, Ph.D.
University of Minnesota
Suite 300
1300 S. Second St.
Minneapolis, MN 55454

Again, thank you for your help and your participation in this study!

PLEASE DO NOT MARK IN THIS AREA

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