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, HOUSTON MEMORIAL SLOAN-KETTERING CANCER CENTER, NEW YORK MINNEAPOLIS CHILDREN'S MEDICAL CENTER MOTT CHILDREN'S HOSPITAL, ANN ARBOR RILEY CHILDREN'S HOSPITAL, INDIANAPOLIS ST. JUDE CHILDREN'S RESEARCH HOSPITAL, MEMPHIS STANFORD UNIV. SCHOOL OF MEDICINE, PALO ALTO UCL SCHOOL OF MEDICINE, SAN FRANCISCO UNIVERSITY OF ALABAMA, BIRMINGHAM UNIVERSITY OF MINNESOTA, MINNEAPOLIS UT-SOUTHWESTERN MEDICAL CENTER, DALLAS ROSWELL PARK, BUFFALO HOSPITAL FOR SICK CHILDREN, TORONTO

Long-Term Follow-Up Study

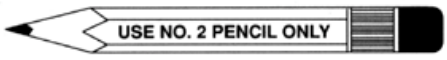
Pregnancy Questionnaire

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.

Written responses must stay within the boxes provided.

CORRECT	INCORRECT
Ⓐ Ⓑ Ⓒ ●	⊗ ✓ ⊙ ◒

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".

PLEASE DO NOT MARK IN THIS AREA

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Please complete a column in this questionnaire for each time that you have had a woman become pregnant by you. 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 mother's age?**

a. Your age	b. Mother'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 your partner 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 fathering a child?** ○ Yes ○ No

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

A 5a. **In the year prior to this pregnancy, did you take any medications to aid in getting pregnant?** ○ Yes ○ No
If yes, specify medication:

5b. **Did the mother take any medications to aid in getting pregnant?** ○ Yes ○ No
If yes, specify medication:

A 6. **Was this pregnancy the result of in-vitro fertilization (the egg fertilized outside the mother and then re-implanted, test tube baby)?** ○ 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:

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

2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
a. Your age / b. Mother's age	a. Your age / b. Mother's age	a. Your age / b. Mother's age	a. Your age / b. Mother's age
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Months:	Months:	Months:	Months:
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
If yes, specify medication:	If yes, specify medication:	If yes, specify medication:	If yes, specify medication:
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
If yes, specify medication:	If yes, specify medication:	If yes, specify medication:	If yes, specify medication:
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
If yes, specify:	If yes, specify:	If yes, specify:	If yes, specify:
Continue on page 4	Continue on page 4	Continue on page 4	Continue on page 4

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1st Pregnancy

A 8a. During the year prior to the start of 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:

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

○ Yes ○ No

If yes, specify treatment:

The following questions ask about illnesses and other information relating to the mother. Please feel free to ask her about any of these items.

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

High blood pressure	○ Yes ○ No ○ Don't know
Toxemia of pregnancy	○ Yes ○ No ○ Don't know
Anemia	○ Yes ○ No ○ Don't know
Threatened miscarriage	○ Yes ○ No ○ Don't know
Diabetes	○ Yes ○ No ○ Don't know
Excessive vomiting (Hyperemesis gravidarum)	○ Yes ○ No ○ Don't know
Bladder or other infections for which she took antibiotics	○ Yes ○ No ○ Don't know
Heart failure	○ Yes ○ No ○ Don't know
Any other illness or complication of the pregnancy?	○ Yes ○ No ○ Don't know

If yes, specify:

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

2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
If yes, specify treatment:	If yes, specify treatment:	If yes, specify treatment:	If yes, specify treatment:
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
If yes, specify treatment:	If yes, specify treatment:	If yes, specify treatment:	If yes, specify treatment:
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
If yes, specify:	If yes, specify:	If yes, specify:	If yes, specify:
Continue on page 6	Continue on page 6	Continue on page 6	Continue on page 6

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1st Pregnancy

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

○ Yes ○ No ○ Don't know

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

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

During the time she smoked, on average, how many cigarettes per day did she 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 the mother drink alcoholic beverages?

○ Yes ○ No ○ Don't know

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

○ Months 1-3
○ Months 4-6
○ Months 7-9
○ Don't know

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

○ Less than 1 drink
○ 1-4 drinks
○ 5-10 drinks
○ 11-30 drinks
○ More than 30 drinks
○ Don't know

B 4. Did the mother take supplemental vitamins during the pregnancy?

○ Yes ○ No ○ Don't know

B 5. At any time during the pregnancy, did a doctor prescribe medicines for her to take?

○ Yes ○ No ○ Don't know

If yes, were these:

antibiotics	○ Yes ○ No ○ Don't know
medicines for high blood pressure	○ Yes ○ No ○ Don't know
supplemental iron	○ Yes ○ No ○ Don't know
medicine for nausea (morning sickness)	○ Yes ○ No ○ Don't know
heart medications	○ Yes ○ No ○ Don't know
other medicines	○ Yes ○ No ○ Don't know

If yes, specify medication:

Continue on page 8 with Pregnancy 1 before going on to Pregnancy 2

2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Months 1-3 ○ Months 4-6 ○ Months 7-9	○ Months 1-3 ○ Months 4-6 ○ Months 7-9	○ Months 1-3 ○ Months 4-6 ○ Months 7-9	○ 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	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	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	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 ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Months 1-3 ○ Months 4-6 ○ Months 7-9 ○ Don't know	○ Months 1-3 ○ Months 4-6 ○ Months 7-9 ○ Don't know	○ Months 1-3 ○ Months 4-6 ○ Months 7-9 ○ Don't know	○ Months 1-3 ○ Months 4-6 ○ Months 7-9 ○ Don't know
○ Less than 1 drink ○ 1-4 drinks ○ 5-10 drinks ○ 11-30 drinks ○ More than 30 drinks ○ Don't know	○ Less than 1 drink ○ 1-4 drinks ○ 5-10 drinks ○ 11-30 drinks ○ More than 30 drinks ○ Don't know	○ Less than 1 drink ○ 1-4 drinks ○ 5-10 drinks ○ 11-30 drinks ○ More than 30 drinks ○ Don't know	○ Less than 1 drink ○ 1-4 drinks ○ 5-10 drinks ○ 11-30 drinks ○ More than 30 drinks ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
If yes, specify medication:	If yes, specify medication:	If yes, specify medication:	If yes, specify medication:
Continue on page 8	**Continue on page 8**	**Continue on page 8**	**Continue on page 8**

1st Pregnancy

B 6. **Did the mother receive chemotherapy or radiation therapy for a tumor, cancer, leukemia, or other illness during the time she was pregnant?**
○ Yes ○ No ○ Don't know

B 7. **Did she ever use marijuana, cocaine, or other recreational drugs during the pregnancy?**
○ Yes ○ No ○ Don't know

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	○
Don't know	○

B 10. **What was the date of birth of the baby or the date the pregnancy ended? (If unknown, leave blank.)**

Mo.	Day	Year

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 10 before going on to Pregnancy 2

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2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No	○ Yes ○ No ○ Yes ○ No ○ Yes ○ No
○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○
Mo. Day Year	Mo. Day Year	Mo. Day Year	Mo. Day Year
If Pregnancy 2 was a live birth or a stillbirth, continue on page 10 before going on to Pregnancy 3	If Pregnancy 3 was a live birth or a stillbirth, continue on page 10 before going on to Pregnancy 4	If Pregnancy 4 was a live birth or a stillbirth, continue on page 10 before going on to Pregnancy 5	If Pregnancy 5 was a live birth or stillbirth, continue on page 10

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

1st Pregnancy

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

- ○ One child
- ○ Twins or more
- ○ Don't know
  - → Return to page 2 and begin next pregnancy

C 2. What is the sex of this child?

○ Male ○ Female

C 3. What 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, miscarriage or an abortion, please leave the rest of this column blank for this pregnancy.

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

Name of child (children):

C 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

C 6. Did this child leave the hospital with his/her mother? ○ Yes ○ No ○ Don't know

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

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Don't know

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

If yes, specify:

C 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.

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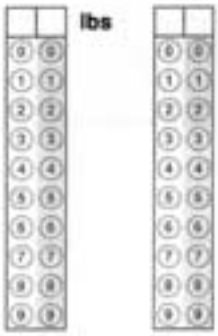
2nd Pregnancy

- ○ One child
- ○ Twins or more
- ○ Don't know
  - → Return to page 2 and begin next pregnancy

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Don't know

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

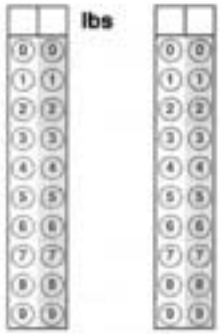
If yes, specify surgery:

3rd Pregnancy

- ○ One child
- ○ Twins or more
- ○ Don't know
  - → Return to page 2 and begin next pregnancy

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Don't know

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

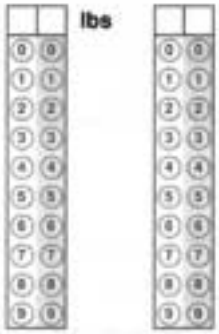
If yes, specify surgery:

4th Pregnancy

- ○ One child
- ○ Twins or more
- ○ Don't know
  - → Return to page 2 and begin next pregnancy

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Don't know

○ Yes ○ No ○ Don't know

If yes, specify:

○ Yes ○ No ○ Don't know

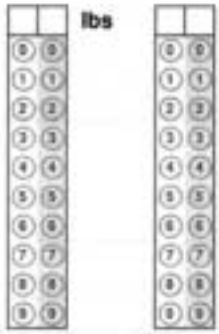
If yes, specify surgery:

5th Pregnancy

- ○ One child
- ○ Twins or more
- ○ Don't know
  - → If more than 5 pregnancies, begin next booklet.

○ Male ○ Female

lbs oz



Name of child (children):

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

○ Yes ○ No ○ Don't know

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Don't know

○ 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!

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