

## New Birth Registration

Parents	Mother	Mother's First Name: <span style="color: red;">mom_first_name</span>		Mother's Middle Name: <span style="color: red;">mom_mid_name</span>			
		Mother's Current Last Name : <span style="color: red;">mom_last_maiden</span>		Last Name on Mother's Birth Certificate: <span style="color: red;">mom_last_current</span>			
		Social Security Number: <span style="color: red;">mom_medrec</span>	Mother's Date of Birth: (MM/DD/YYYY) <span style="color: red;">mom_dob [mom_age]calculated</span>				
		Infant's First Name: <span style="color: red;">inf_first_name</span>			Infant's Middle Name: <span style="color: red;">inf_mid_name</span>		
		Infant's Last Name: <span style="color: red;">inf_last_name</span>			Infant's Name Suffix <span style="color: red;">inf_suffix</span> (e.g. Jr., 2 <sup>nd</sup> , III):		
Infant	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <span style="color: red;">sex_of_inf</span> <input type="checkbox"/> Undetermined		Plurality: <span style="color: red;">plurality</span>	Birth Order: <span style="color: red;">birth_orde</span>	Medical Record No.: <span style="color: red;">inf_medrec</span>		
	Date of Birth: (MM/DD/YYYY) <span style="color: red;">inf_dob</span>		Time of Birth: (HH:MM) <span style="color: red;">inf_tob</span> <input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> military (24-hour time)				
Parents	Infant	Was child born in this facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If child was <b>not</b> born in this facility, please answer the following questions:					
		In what type of place was the infant born? <input type="checkbox"/> Freestanding Birth Center (regulated by DOH) <input type="checkbox"/> Home (unknown intent) <input type="checkbox"/> Home (intended) <input type="checkbox"/> Clinic / Doctor's Office (not regulated by DOH) <input type="checkbox"/> Home (unintended) <input type="checkbox"/> Other <span style="color: red;">inst_type</span>		If New York State Birthing Center, enter its name: <span style="color: red;">hospcode</span>			
		In what county was the child born?					
Parents	Birthplace	Institution <span style="color: red;">inst_code</span>					
		Site of Birth, If <b>Other</b> Type of Place: <span style="color: red;">site_of_birth</span>		Street Address – if other than Hospital / Birthing Center:			
		If place of infant's birth was other than Hospital or Birthing Center: City, town or village where birth occurred: <span style="color: red;">dis_code</span> Zip / Postal Code: <span style="color: red;">zip_postal</span>					
Infant's Pediatrician/Family Practitioner: <span style="float: right;">NBS</span>							
Parents	Attendant	<b>Attendant's Information:</b>					
		License Number: <span style="color: red;">atth_lic</span>	Name: <i>First</i>	<i>Middle</i>	<i>Last</i>		
	Certifier	Title: (Select one) <span style="color: red;">att_type</span> <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Doctor of Osteopathy <input type="checkbox"/> Licensed Midwife (CNM) <input type="checkbox"/> Licensed Midwife (CM) <input type="checkbox"/> Other					
		<b>Certifier's Information:</b> <span style="color: red;">cert_num</span> <input type="checkbox"/> Check here if the Certifier is the same as the Attendant (otherwise enter information below)					
		License Number:	Name: <i>First</i>	<i>Middle</i>	<i>Last</i>		
		Title: (Select one) <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Doctor of Osteopathy <input type="checkbox"/> Licensed Midwife (CNM) <input type="checkbox"/> Licensed Midwife (CM) <input type="checkbox"/> Other					
Parents	Payor	<b>Primary Payor for this Delivery:</b> Select one: <span style="color: red;">primary_pa</span>					
		<input type="checkbox"/> Medicaid / Family Health Plus	<input type="checkbox"/> Private Insurance	<input type="checkbox"/> Indian Health Service			
		<input type="checkbox"/> CHAMPUS / TRICARE	<input type="checkbox"/> Other Government / Child Health Plus B	<input type="checkbox"/> Other			
		<input type="checkbox"/> Self-pay					
		If Medicaid is not the primary payor, is it a secondary payor for this delivery? <span style="color: red;">med_pay</span> <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the mother enrolled in an HMO or other managed care plan? <span style="color: red;">medicaid_m</span> <input type="checkbox"/> Yes <input type="checkbox"/> No			



Infant					
Infant	<b>If Multiple Births:</b> Number of Live Births: <input type="text"/> <small>mu_lb</small>		Number of Fetal Deaths: <input type="text"/> <small>mu_fd</small>		<b>Birth Weight:</b> <input type="text"/> <small>birth_wgt</small>
	If birth weight < 1250 grams (2 lbs. 12 oz.), reason(s) for delivery at a less than level III hospital: <i>(Only if applicable)</i> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <small>lev3_none lev3_unk</small>				
	Select all that apply: <input type="checkbox"/> Rapid / Advanced Labor <small>lev3_rapid</small> <input type="checkbox"/> Bleeding <small>lev3_bleed</small> <input type="checkbox"/> Fetus at Risk <small>lev3_risk</small> <input type="checkbox"/> Severe pre-eclampsia <small>lev3_eclamp</small> <input type="checkbox"/> Woman Refused Transfer <small>lev3_ref</small> <input type="checkbox"/> Other <i>(specify)</i> <small>lev3_oth lev3_lit</small>				
<b>Infant Transferred:</b> <input type="checkbox"/> Within 24 hrs <input type="checkbox"/> After 24 hrs. <input type="checkbox"/> Not transferred <small>transfer_i</small>			<b>NYS Hospital Infant Transferred To:</b> <input type="text"/> <small>hosp_trsfr</small>		<b>State/Terr./Province:</b> <input type="text"/>
Birth Information	<b>Apgar Scores</b> 1 minute: <input type="text"/> <small>apgar_1_mi</small> 5 minutes: <input type="text"/> <small>apgar_5_mi</small> 10 minutes: <input type="text"/> <small>apgar_10_mi</small>		<b>Is the Infant Alive?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred / Status Unknown <input type="text"/> <small>Inf_status</small>	<b>Clinical Estimate of Gestation: (Weeks)</b> <input type="text"/> <small>est_gest</small>	<b>Newborn Treatment Given:</b> <input type="checkbox"/> Conjunctivitis only <input type="checkbox"/> Vitamin K only <input type="checkbox"/> Both <input type="checkbox"/> Neither
	<b>How is infant being fed at discharge? (Select one)</b> <input type="checkbox"/> Breast Milk Only <input type="checkbox"/> Formula Only <input type="checkbox"/> Both Breast Milk and Formula <input type="checkbox"/> Other <input type="checkbox"/> Do Not Know <small>infant_fee</small>				
Newborn Screening	<b>Newborn Blood-Spot Screening</b> Screening Lab ID Number: <i>(9-digits)</i> <input type="text"/>			<b>Reason if Lab ID is not submitted:</b> <input type="checkbox"/> No NBS Lab ID because infant died prior to test <input type="checkbox"/> No NBS Lab ID because infant transferred prior to test <input type="checkbox"/> Lab ID is unknown / illegible <input type="checkbox"/> Refused NBS	
	NBS				
Hepatitis B	<b>Hepatitis B Inoculation</b> Immunization Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>hepb_uniz</small> Date: <i>(MM/DD/YYYY)</i> ____ / ____ / ____ Mfr: _____ Lot: _____			Immunoglobulin Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>hepb_glob</small> Date: <i>(MM/DD/YYYY)</i> ____ / ____ / ____ Mfr: _____ Lot: _____	
	<b>Abnormal Conditions of the Newborn:</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <small>noinfo_abn abn_unk</small> Select all that apply <input type="checkbox"/> Assisted ventilation required immediately following delivery <small>o5min_av_a</small> <input type="checkbox"/> NICU Admission <small>nicu_infan</small> <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <small>abn_sep</small> <input type="checkbox"/> Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention) <small>abn_injury</small> <input type="checkbox"/> Assisted ventilation required for more than six hours <small>o30min_avx</small> <input type="checkbox"/> Newborn given surfactant replacement therapy <small>surfact_ab</small> <input type="checkbox"/> Seizures or serious neurologic dysfunction <small>abn_seiz</small>				

## Congenital Anomalies



<input type="checkbox"/> None of the listed <input type="checkbox"/> Unknown at this time <span style="color: red;">none_congm   unk_at</span> Select all that apply		Diagnosed Prenatally?	If Yes, please indicate all methods used:
Yes No <input type="checkbox"/> <input type="checkbox"/>	Anencephaly <span style="color: red;">anenceph_c</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">anen_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">anen_lev2</span> <input type="checkbox"/> MSAFP / Triple Screen <span style="color: red;">anen_screen</span> <input type="checkbox"/> Amniocentesis <span style="color: red;">anen_amnio</span> <input type="checkbox"/> Other <span style="color: red;">anen_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">anen_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Meningomyelocele/Spina Bifida <span style="color: red;">m_spina</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">menin_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">menin_lev2</span> <input type="checkbox"/> MSAFP / Triple Screen <span style="color: red;">menin_screen</span> <input type="checkbox"/> Amniocentesis <span style="color: red;">menin_amnio</span> <input type="checkbox"/> Other <span style="color: red;">menin_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">menin_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Cyanotic Congenital Heart Disease <span style="color: red;">c_heart</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">cyan_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">cyan_lev2</span> <input type="checkbox"/> Other <span style="color: red;">cyan_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">cyan_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Congenital Diaphragmatic Hernia <span style="color: red;">diaphragm_h</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">congen_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">congen_lev2</span> <input type="checkbox"/> Other <span style="color: red;">congen_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">congen_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Omphalocele <span style="color: red;">omphalo</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">omph_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">omph_lev2</span> <input type="checkbox"/> Other <span style="color: red;">omph_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">omph_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Gastroschisis <span style="color: red;">gastros</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">gastro_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">gastro_lev2</span> <input type="checkbox"/> Other <span style="color: red;">gastro_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">gastro_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Limb Reduction Defect <span style="color: red;">limb_reduc</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">limb_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">limb_lev2</span> <input type="checkbox"/> Other <span style="color: red;">limb_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">limb_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Cleft lip with or without Cleft Palate <span style="color: red;">cleft_lipx</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">lip_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">lip_lev2</span> <input type="checkbox"/> Other <span style="color: red;">lip_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">lip_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Cleft Palate Alone <span style="color: red;">cleft</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">pala_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">pala_lev2</span> <input type="checkbox"/> Other <span style="color: red;">pala_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">pala_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Down Syndrome <span style="color: red;">down_sy</span> <input type="checkbox"/> Karyotype confirmed <span style="color: red;">down_ka    down_kp</span> <input type="checkbox"/> Karyotype pending	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">down_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">down_lev2</span> <input type="checkbox"/> MSAFP / Triple Screen <span style="color: red;">down_screen</span> <input type="checkbox"/> CVS <span style="color: red;">down_cvs</span> <input type="checkbox"/> Amniocentesis <span style="color: red;">down_amnio</span> <input type="checkbox"/> Other <span style="color: red;">down_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">down_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Other Chromosomal Disorder <span style="color: red;">chrom_di</span> <input type="checkbox"/> Karyotype confirmed <span style="color: red;">chro_kc    chro_kp</span> <input type="checkbox"/> Karyotype pending	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">chrom_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">chrom_lev2</span> <input type="checkbox"/> MSAFP / Triple Screen <span style="color: red;">chrom_screen</span> <input type="checkbox"/> CVS <span style="color: red;">chrom_cvs</span> <input type="checkbox"/> Amniocentesis <span style="color: red;">chrom_amnio</span> <input type="checkbox"/> Other <span style="color: red;">chrom_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">chrom_unk</span>
Yes No <input type="checkbox"/> <input type="checkbox"/>	Hypospadias <span style="color: red;">hypospadias</span>	Yes No <input type="checkbox"/> <input type="checkbox"/> <span style="color: red;">hypos_prenat</span>	<input type="checkbox"/> Level II Ultrasound <span style="color: red;">hypos_lev2</span> <input type="checkbox"/> Other <span style="color: red;">hypos_oth</span> <input type="checkbox"/> Unknown <span style="color: red;">hypos_unk</span>

Congenital Anomalies

## Labor & Delivery

<b>Labor &amp; Delivery</b>	<b>Mother Transferred in Antepartum:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">mom_trsf</span>	<b>NYS Facility Mother Transferred From:</b> <span style="color: red;">hosp_mom_t</span>	<b>State/Terr./Province:</b> <span style="color: red;">trans_state</span>
	<b>Mother's Weight at Delivery:</b> <span style="color: red;">delv_wt</span> <span style="float: right;">lbs.</span>		
<b>Method of Delivery</b>	<b>Fetal Presentation: (select one)</b> <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <span style="color: red;">pres_del</span>		
	<b>Route &amp; Method: (select one)</b> <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps – Mid <input type="checkbox"/> Forceps – Low / Outlet <input type="checkbox"/> Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown <span style="color: red;">route_main</span>		
	<b>Cesarean Section History:</b> <input type="checkbox"/> Previous C-Section <span style="color: red;">prev_cs</span> <input style="width: 40px; height: 20px;" type="text"/> Number <span style="color: red;">num_cs</span>		
	<b>Attempted Procedures:</b> Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">forceps</span> Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">vacuum_met</span>		
<b>Method of Delivery</b>	<b>Trial Labor:</b> If Cesarean section, was trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">trial_lab</span>		
	<b>Indications for C-Section:</b> <input type="checkbox"/> Unknown <span style="color: red;">c_sec_unk</span> Select all that apply <input type="checkbox"/> Failure to progress <span style="color: red;">c_sec_progress</span> <input type="checkbox"/> Malpresentation <span style="color: red;">c_sec_malp</span> <input type="checkbox"/> Previous C-Section <span style="color: red;">c_sec_previous</span> <input type="checkbox"/> Fetus at Risk / NFS <span style="color: red;">fetus_at_r</span> <input type="checkbox"/> Maternal Condition – Not Pregnancy Related <span style="color: red;">mat_cond_n</span> <input type="checkbox"/> Maternal Condition – Pregnancy Related <span style="color: red;">mat_cond_p</span> <input type="checkbox"/> Refused VBAC <span style="color: red;">ref_vbac</span> <input type="checkbox"/> Elective <span style="color: red;">c-sec_elec</span> <input type="checkbox"/> Other <span style="color: red;">other_csin</span>		
	<b>Indications for Vacuum:</b> <input type="checkbox"/> Unknown <span style="color: red;">vac_unk</span> Select all that apply <input type="checkbox"/> Failure to progress <span style="color: red;">vac_progress</span> <input type="checkbox"/> Fetus at Risk <span style="color: red;">vac_risk</span> <input type="checkbox"/> Other <span style="color: red;">vac_oth</span>	<b>Indications for Forceps:</b> <input type="checkbox"/> Unknown <span style="color: red;">forceps_unk</span> Select all that apply <input type="checkbox"/> Failure to progress <span style="color: red;">forceps_fail</span> <input type="checkbox"/> Fetus at Risk <span style="color: red;">forceps_risk</span> <input type="checkbox"/> Other <span style="color: red;">forceps_oth</span>	
<b>Labor</b>	<b>Onset of Labor</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <span style="color: red;">labor_none labor_unk</span> Select all that apply <input type="checkbox"/> Prolonged Rupture of Membranes -- (12 or more hours) <span style="color: red;">room_12</span> <input type="checkbox"/> Premature Rupture of Membranes -- (prior to labor) <span style="color: red;">prom</span> <input type="checkbox"/> Precipitous Labor -- (less than 3 hours) <span style="color: red;">labor_precip</span> <input type="checkbox"/> Prolonged Labor (20 or more hours) <span style="color: red;">labor_pro</span>		
<b>Characteristics</b>	<b>Characteristics of Labor &amp; Delivery</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <span style="color: red;">char_none char_unk</span> Select all that apply <input type="checkbox"/> Induction of Labor – AROM <span style="color: red;">ind_aron</span> <input type="checkbox"/> Induction of Labor – Medicinal <span style="color: red;">ind_med</span> <input type="checkbox"/> Augmentation of Labor <span style="color: red;">augment</span> <input type="checkbox"/> Steroids <span style="color: red;">ad_steroids</span> <input type="checkbox"/> Antibiotics <span style="color: red;">ip_abx</span> <input type="checkbox"/> Chorioamnionitis <span style="color: red;">chorio</span> <input type="checkbox"/> Meconium Staining <span style="color: red;">mecon</span> <input type="checkbox"/> Fetal Intolerance <span style="color: red;">nrfs</span> <input type="checkbox"/> External Electronic Fetal Monitoring <span style="color: red;">efm</span> <input type="checkbox"/> Internal Electronic Fetal Monitoring <span style="color: red;">ifm</span>		

## Labor & Delivery

<b>Maternal Morbidity</b>	<p><b>Maternal Morbidity</b></p> <p><input type="checkbox"/> None   <input type="checkbox"/> Unknown at this time  <span style="color: red;">morbi_none   morbi_unk</span></p> <p>Select all that apply</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><input type="checkbox"/> Maternal Transfusion <span style="color: red;">mat_tx</span></p> <p><input type="checkbox"/> Unplanned Hysterectomy <span style="color: red;">morbi_hyst</span></p> <p><input type="checkbox"/> Postpartum transfer to a higher level of care <span style="color: red;">mat_pp_trans</span></p> </div> <div style="width: 30%;"> <p><input type="checkbox"/> Perineal Laceration (3<sup>rd</sup> / 4<sup>th</sup> Degree) <span style="color: red;">peri_lac</span></p> <p><input type="checkbox"/> Admit to ICU <span style="color: red;">morbi_icu</span></p> </div> <div style="width: 30%;"> <p><input type="checkbox"/> Ruptured Uterus <span style="color: red;">ut_rupt</span></p> <p><input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery <span style="color: red;">morbi_oper</span></p> </div> </div>
<b>Anesthesia / Analgesia</b>	<p><b>Anesthesia / Analgesia</b></p> <p><input type="checkbox"/> None   <input type="checkbox"/> Unknown at this time  <span style="color: red;">none_anes   unk_anes</span></p> <p>Select all that apply</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p><input type="checkbox"/> Epidural (Caudal) <span style="color: red;">epidural_a</span></p> <p><input type="checkbox"/> General Inhalation <span style="color: red;">gen_inhalx</span></p> <p><input type="checkbox"/> Pudendal <span style="color: red;">pudendal_a</span></p> </div> <div style="width: 30%;"> <p><input type="checkbox"/> Local <span style="color: red;">local_anes</span></p> <p><input type="checkbox"/> Paracervical <span style="color: red;">paracerv_a</span></p> </div> <div style="width: 30%;"> <p><input type="checkbox"/> Spinal <span style="color: red;">spinal_ane</span></p> <p><input type="checkbox"/> General Intravenous <span style="color: red;">gen_intrax</span></p> </div> </div> <p>Was an analgesic administered?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No <span style="color: red;">analgesia</span></p>
<b>Procedures</b>	<p><b>Other Procedures Performed at Delivery</b></p> <p><input type="checkbox"/> None   <input type="checkbox"/> Unknown at this time  <span style="color: red;">othproc_no   othproc_unk</span></p> <p>Select all that apply</p> <p><input type="checkbox"/> Episiotomy and Repair <span style="color: red;">epis_othpr</span>   <input type="checkbox"/> Sterilization <span style="color: red;">steril_oth</span></p>

## Mother

Medical Record Number: mom\_medrec

**Mother's Education:** *(select one)* mom\_educ

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 8 <sup>th</sup> grade or less                        | <input type="checkbox"/> Some college credit, but no degree | <input type="checkbox"/> Master's degree  |
| <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> grade; no diploma | <input type="checkbox"/> Associate's degree                 | <input type="checkbox"/> Doctorate degree |
| <input type="checkbox"/> High school graduate; or GED                         | <input type="checkbox"/> Bachelor's degree                  |   |

City of Birth:	State/Terr./Province of Birth: <span style="color: red;">mom_statex</span>	Country of Birth, if not USA: <span style="color: red;">mom_countr</span>
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**Hispanic Origin:**

Select all that apply

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> No, not Spanish/Hispanic/Latina<br><span style="color: red;">mhis_no</span> | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana<br><span style="color: red;">mhis_me</span> | <input type="checkbox"/> Yes, Puerto Rican <span style="color: red;">mhis_pr</span> |
| <input type="checkbox"/> Yes, Cuban <span style="color: red;">mhis_cu</span>                         | <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latina<br><span style="color: red;">mhis_ot</span>      |   |

Specify:

**Race:**

Select all that apply

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> White/Caucasian <span style="color: red;">mom_whi</span>       | <input type="checkbox"/> Black or African American <span style="color: red;">mom_bla</span> | <input type="checkbox"/> Asian Indian <span style="color: red;">mom_si</span>     |
| <input type="checkbox"/> Chinese <span style="color: red;">mom_chi</span>               | <input type="checkbox"/> Filipino <span style="color: red;">mom_fil</span>                  | <input type="checkbox"/> Japanese <span style="color: red;">mom_jap</span>        |
| <input type="checkbox"/> Korean <span style="color: red;">mom_kor</span>                | <input type="checkbox"/> Vietnamese <span style="color: red;">mom_vie</span>                | <input type="checkbox"/> Native Hawaiian <span style="color: red;">mom_nha</span> |
| <input type="checkbox"/> Guamanian or Chamorro <span style="color: red;">mom_gua</span> | <input type="checkbox"/> Samoan <span style="color: red;">mom_sam</span>                    |   |

American Indian or Alaska Native Tribe:

mom\_aina

Other Asian mom\_oas

Other Pacific Islander mom\_opi Specify:

Other mom\_oth Specify:

**Residence Address**

Street Address: mom\_res\_add\_house mom\_res\_add\_dir  
mom\_res\_add\_name mom\_res\_add\_st mom\_res\_add\_post\_dir mom\_res\_add\_apt

State/Terr./Province: <span style="color: red;">mom_state</span>	County: <span style="color: red;">res_county</span>	City, Town or Village: <span style="color: red;">mom_add_lit</span>
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Zip/Postal Code: <span style="color: red;">reszip5</span> <span style="color: red;">reszip5ext</span>	Mother's Country of Residence, if not USA: <span style="color: red;">res_mom_countr</span>	U.S./Canadian Phone Number: <span style="color: red;">mom_phone</span>
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**Mailing Address – Most Recent**

Check here if the mailing address is the same as the residence address *(otherwise enter information below)*  
mail\_add\_other

Mailing Address: res\_mailing\_house res\_mailing\_dir  
res\_mailing\_name res\_mailing\_st res\_mailing\_post\_dir res\_mailing\_apt

City, Town or Village: <span style="color: red;">mom_add_lit</span>	State/Terr./Province <span style="color: red;">mail_state:</span>	Country, if not USA: <span style="color: red;">mail_countr</span>	Zip/Postal Code: <span style="color: red;">res_mailing_zip</span>
--	--	--	--

**Employment History**

Employed while Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">mom_employ</span>	Current / Most Recent Occupation: <span style="color: red;">mom_occup</span>	Kind of Business / Industry: <span style="color: red;">mom_industry</span>
--	---	---

Name of Company or Firm:	Address:
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City:	State/Territory/Province:	Zip / Postal Code:
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Parents

Mother's Demographics

Mother's Demographics

Mother's Residence

Mother's Mailing Address

Employment

## Father or Second Parent

Will the mother and father be executing an Acknowledgement of Paternity? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <i>pat_aff paternity_ind</i>	What type of certificate is required? <input type="checkbox"/> Mother / Father <input type="checkbox"/> Mother / Mother
---	--

Parent's First Name: <i>dad_first_name</i>	Parent's Middle Name: <i>dad_mid_name</i>
--	---

Parent's Current Last Name: <i>dad_last_name</i>	Last Name on Parent's Birth Certificate:
--	--

Parent's Name Suffix <i>dad_suffix</i> (e.g. Jr., 2 <sup>nd</sup> , III):	Social Security Number: - -	
--	--------------------------------	--

<b>Demographics</b>			
Parent's Date of Birth: <i>dad_dob [dad_age] calculated</i> (MM/DD/YYYY)  / /	Education: (select one) <i>dad_educ</i> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> grade; no diploma <input type="checkbox"/> High school graduate; or GED	<input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate degree

City of Birth:	State/Terr./Province of Birth: <i>dad_bp_sta</i>	Country of Birth, if not USA: <i>dad_bp_cou</i>
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Hispanic Origin: Select all that apply <input type="checkbox"/> No, not Spanish/Hispanic/Latino <i>dhis_no</i> <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <i>dhis_me</i> <input type="checkbox"/> Yes, Puerto Rican <i>dhis_pr</i> <input type="checkbox"/> Yes, Cuban <i>dhis_cu</i> <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino <i>dhis_ot</i> Specify:		
---	--	--

Race: Select all that apply <input type="checkbox"/> White/Caucasian <i>dad_who</i> <input type="checkbox"/> Black or African American <i>dad_bla</i> <input type="checkbox"/> Asian Indian <i>dad_si</i> <input type="checkbox"/> Chinese <i>dad_chi</i> <input type="checkbox"/> Filipino <i>dad_fil</i> <input type="checkbox"/> Japanese <i>dad_jap</i> <input type="checkbox"/> Korean <i>dad_kor</i> <input type="checkbox"/> Vietnamese <i>dad_vie</i> <input type="checkbox"/> Native Hawaiian <i>dad_nha</i> <input type="checkbox"/> Guamanian or Chamorro <i>dad_gua</i> <input type="checkbox"/> Samoan <i>dad_sam</i> <input type="checkbox"/> American Indian or Alaska Native Tribe: <i>dad_aina</i> <input type="checkbox"/> Other Asian <i>dad_oas</i> Specify: <input type="checkbox"/> Other Pacific Islander <i>dad_opi</i> Specify: <input type="checkbox"/> Other <i>dad_oth</i> Specify:		
---	--	--

<b>Residence Address</b> <input type="checkbox"/> Check here if the parent's residence address is the same as the mother's address (otherwise enter information below)		
--	--	--

Street Address: <i>dad_res_add_house dad_res_add_dir</i> <i>dad_res_add_name dad_res_add_st dad_res_add_post_dir dad_res_add_apt</i>		
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City, Town or Village: <i>dad_add_lit</i>	State / Territory / Province: <i>dad_mom_statex</i>
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Parent's Country of Residence, if not USA: <i>dad_countr</i>	Zip / Postal Code: <i>dad_reszip5</i>
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### Employment History

Current / Most Recent Occupation: <i>dad_occup</i>	Kind of Business / Industry: <i>dad_industry</i>
---	---

Name of Company or Firm:	Address:
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City:	State / Territory / Province:	Zip / Postal Code:
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Parents  
Father's or Second Parent's Demographics

## Prenatal History

Parents	Prenatal History	Did mother receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">pre_yes</span>	Primary Prenatal Care Provider Type: <span style="color: red;">primary_pr</span> <input type="checkbox"/> MD / DO / C(N)M / HMO <input type="checkbox"/> No Information <input type="checkbox"/> Clinic <input type="checkbox"/> No Provider <input type="checkbox"/> Other		Did mother participate in WIC? <span style="color: red;">wic_mompar</span> <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<b>Key Pregnancy Dates</b> (MM/DD/YYYY) <span style="color: red;">[gestdays] calculated</span> Date of Last Menses: <span style="color: red;">Imp_date</span> Estimated Due Date:      Date of First Prenatal Visit: <span style="color: red;">first_visit_date</span> Date of Last Prenatal Visit: <span style="color: red;">last_visit_date</span>				
		<b>Prenatal Visits</b> <span style="color: red;">care_days est_pnc_mo calc_trimester</span> Total Number of Prenatal Visits: <span style="color: red;">num_visits</span>				
		<b>Pregnancy History</b> <span style="color: red;">[calc_birth_his calc_birth_all] calculated</span>				
Prenatal History	Previous Live Births: <span style="color: red;">tot_preg</span> Now Living: None or Number <input type="checkbox"/> <span style="color: red;">live_livex</span> Now Dead: None or Number <input type="checkbox"/> <span style="color: red;">live_deadx</span>		Previous Spontaneous Terminations: Less than 20 Weeks: None or Number <input type="checkbox"/> <span style="color: red;">u20_spon_p</span> 20 Weeks or More: None or Number <input type="checkbox"/> <span style="color: red;">o20_spon_p</span>		Previous Induced Terminations: None or Number <input type="checkbox"/> <span style="color: red;">Induced_pr</span>	
	Total Prior Pregnancies: None or Number <input type="checkbox"/> <span style="color: red;">tot_preg</span>		First Live Birth: (MM / YYYY) <span style="color: red;">first_livex</span>		Last Live Birth: (MM / YYYY) <span style="color: red;">last_livex</span>	
	Last Other Pregnancy Outcome: (MM / YYYY) <span style="color: red;">last_oth</span>		Prepregnancy Weight: <span style="color: red;">pre_preg_wt</span> lbs.		Height: <span style="color: red;">mom_ht</span> ft. <span style="color: red;">in.</span>	

## Prenatal Care

Risk Factors	<b>Risk Factors in this Pregnancy</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <span style="color: red;">none_medri unk_risk</span> Select all that apply: <input type="checkbox"/> Gestational Diabetes <span style="color: red;">diabetes_g</span> <input type="checkbox"/> Prepregnancy Hypertension <span style="color: red;">hyper_chro</span> <input type="checkbox"/> Gestational hypertension <span style="color: red;">hyper_preg</span> <input type="checkbox"/> Prepregnancy Diabetes <span style="color: red;">diabetes_m</span> <input type="checkbox"/> Previous Preterm Births <span style="color: red;">pre_term_m</span> <input type="checkbox"/> Abruption Placenta <span style="color: red;">abrupt</span> <input type="checkbox"/> Eclampsia <span style="color: red;">eclampsiax</span> <input type="checkbox"/> Other Serious Chronic Illnesses <span style="color: red;">othe_ill</span> <input type="checkbox"/> Prelabor Referred for High Risk Care <span style="color: red;">prelab_ref</span> <input type="checkbox"/> Other Vaginal Bleeding <span style="color: red;">vag_</span> <input type="checkbox"/> Previous Low Birthweight Infant <input type="checkbox"/> Other Poor Pregnancy Outcomes <span style="color: red;">poor_preg</span> <input type="checkbox"/> Pregnancy resulted from infertility treatment (if yes, check all that apply) <span style="color: red;">inferti</span> <input type="checkbox"/> Fertility-enhancing drugs, artificial or intrauterine insemination <span style="color: red;">infert_med</span> <input type="checkbox"/> Assisted reproductive technology (e.g. IVF, GIFT) <b>Number of Embryos Implanted:</b> (if applicable) <input type="text"/> <span style="color: red;">Infert_art embryos</span>				
	Infections	<b>Infections Present and/or Treated During Pregnancy</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <span style="color: red;">none unk_inf</span> Select all that apply: <input type="checkbox"/> Syphilis <span style="color: red;">syph_medri</span> <input type="checkbox"/> Herpes Simplex Virus (HSV) <span style="color: red;">infec_hsv</span> <input type="checkbox"/> Chlamydia <span style="color: red;">chlamyd</span> <input type="checkbox"/> Gonorrhea <span style="color: red;">infec_gc</span> <input type="checkbox"/> Hepatitis C <span style="color: red;">hepc</span> <input type="checkbox"/> Tuberculosis <span style="color: red;">tb_medrisk</span> <input type="checkbox"/> Rubella <span style="color: red;">rubella_me</span> <input type="checkbox"/> Hepatitis B <span style="color: red;">hepb</span> <input type="checkbox"/> Bacterial Vaginosis <span style="color: red;">bac_vag</span>			

Parents	Other Risk Factors	<b>Other Risk Factors</b> Smoking Before or During Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="color: red;">tobacco_yn</span>																	
		<b>List Number of Packs OR Cigarettes Smoked Per DAY</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"></td> <td style="width: 20%;">3 Months Prior to Pregnancy</td> <td style="width: 20%;">First Three Months of Pregnancy</td> <td style="width: 20%;">Second Three Months of Pregnancy</td> <td style="width: 20%;">Third Trimester of Pregnancy</td> </tr> <tr> <td></td> <td>Packs OR Cigarettes</td> <td>Packs OR Cigarettes</td> <td>Packs OR Cigarettes</td> <td>Packs OR Cigarettes</td> </tr> <tr> <td></td> <td><span style="color: red;">smo_pri</span></td> <td><span style="color: red;">smo_1st</span></td> <td><span style="color: red;">smo_2nd</span></td> <td><span style="color: red;">smo_3rd</span></td> </tr> </table>						3 Months Prior to Pregnancy	First Three Months of Pregnancy	Second Three Months of Pregnancy	Third Trimester of Pregnancy		Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes		<span style="color: red;">smo_pri</span>	<span style="color: red;">smo_1st</span>
	3 Months Prior to Pregnancy	First Three Months of Pregnancy	Second Three Months of Pregnancy	Third Trimester of Pregnancy															
	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes															
	<span style="color: red;">smo_pri</span>	<span style="color: red;">smo_1st</span>	<span style="color: red;">smo_2nd</span>	<span style="color: red;">smo_3rd</span>															

Prenatal Care				
Other Risk	<b>Other Risk Factors</b>			
	Alcohol Consumed During This Pregnancy? <b>alcohol_ot</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Drinks per Week: <b>num_drink</b>	Illegal Drugs Used During This Pregnancy? <b>idrug_y</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Obstetric Procedures	<b>Obstetric Procedures</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>none_obpro</b> <b>proc_tocol</b>			
	Select all that apply <input type="checkbox"/> Cervical Cerclage <b>proc_cer</b>			
	<input type="checkbox"/> Fetal Genetic Testing <b>genetic_test</b>			
If woman was 35 or over, was fetal genetic testing offered? <input type="checkbox"/> Yes <input type="checkbox"/> No, Too Late <input type="checkbox"/> No, Other Reason <b>amnio_offe</b>				
	<b>Serological Test for Syphilis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>sero_test</b>	<b>Date of Test:</b> (MM/DD/YYYY)	<b>Reason, if No Test:</b> <input type="checkbox"/> Mother refused <input type="checkbox"/> Religious reasons <input type="checkbox"/> No prenatal care <input type="checkbox"/> Other <input type="checkbox"/> No time before delivery	

Interview/Records



**Survey of Mother (in hospital)** *pre\_yes*

Did you receive prenatal care?  Yes  No *(If 'Yes' please answer question 1. Otherwise skip to question 2.)*

1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?

- |   | Yes                      | No                       |                      |
|---|--------------------------|--------------------------|----------------------|
| a. How smoking during pregnancy could affect your baby?               | <input type="checkbox"/> | <input type="checkbox"/> | <i>hc_smoking</i>    |
| b. How drinking alcohol during your pregnancy could affect your baby? | <input type="checkbox"/> | <input type="checkbox"/> | <i>hc_drinking</i>   |
| c. How using illegal drugs could affect your baby?                    | <input type="checkbox"/> | <input type="checkbox"/> | <i>hc_drugs</i>      |
| d. How long to wait before having another baby?                       | <input type="checkbox"/> | <input type="checkbox"/> | <i>wait_baby</i>     |
| e. Birth control methods to use after your pregnancy?                 | <input type="checkbox"/> | <input type="checkbox"/> | <i>birth_control</i> |
| f. What to do if your labor starts early?                             | <input type="checkbox"/> | <input type="checkbox"/> | <i>early_labor</i>   |
| g. How to keep from getting HIV (the virus that causes AIDS)?         | <input type="checkbox"/> | <input type="checkbox"/> | <i>hiv</i>           |
| h. Physical abuse to women by their husbands or partners?             | <input type="checkbox"/> | <input type="checkbox"/> | <i>abuse</i>         |

2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities? *num\_exer\_q* Times per week:

3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums? *gums*  Yes  
 No

4. During your pregnancy, would you say that you were: *(select one)* *depression*

<input type="checkbox"/> Not depressed at all	<input type="checkbox"/> A little depressed
<input type="checkbox"/> Moderately depressed	<input type="checkbox"/> Very depressed
<input type="checkbox"/> Very depressed and had to get help	

5. Thinking back to just before you were pregnant, how did you feel about becoming pregnant? *preg\_planx*

<input type="checkbox"/> You wanted to be pregnant sooner	<input type="checkbox"/> You wanted to be pregnant later
<input type="checkbox"/> You wanted to be pregnant then	<input type="checkbox"/> You didn't want to be pregnant then or at any time in the future

**Chart Review (Prenatal and Medical)**

1a. Copy of prenatal record in chart? *prenatal\_rec*

<input type="checkbox"/> Yes, Full Record	<input type="checkbox"/> Yes, Prenatal Summary Only
<input type="checkbox"/> No	

1b. Was formal risk assessment in prenatal chart? *formal\_risk*

<input type="checkbox"/> Yes, with Social Assessment	<input type="checkbox"/> Yes, without Social Assessment
<input type="checkbox"/> No	

1c. Was MSAFP / triple screen test offered? *msafp\_offe*

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> No, Too Late	

1d. Was MSAFP / triple screen test done? *msafp\_done*

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery? *mom\_hospitalized*

**Admission and Discharge Information**

**Mother**

Admission Date for Delivery <i>(MM/DD/YYYY)</i> <i>mom_adm</i>	Discharge Date <i>(MM/DD/YYYY)</i> <i>mom_dischg</i>
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**Infant** *status\_inf*

Discharge Date <i>(MM/DD/YYYY)</i> <i>inf_dischg</i>	<input type="checkbox"/> Discharged Home	<input type="checkbox"/> Infant Died at Birth Hospital
	<input type="checkbox"/> Infant Still in Hospital	<input type="checkbox"/> Infant Discharged to Foster Care/Adoption
	<input type="checkbox"/> Infant Transferred Out	<input type="checkbox"/> Unknown

laborParents  
Survey of Mother (in hospital)

Chart Review (Prenatal and Medical)

Admission & Discharge

