

Mother's Name:	Mother's Med. Rec. Number:
----------------	----------------------------

New York State Birth Certificate and Statewide Perinatal Data System Work Booklet

New Birth Registration

Parents	Mother	Mother's Name: <i>First</i> <i>Middle</i> <i>Maiden Last Name</i> <i>Current Last Name</i>
		Social Security Number: <i>- -</i> Mother's Date of Birth: (MM/DD/YYYY) <i>/ /</i>
Infant		Infant's Name: <i>First</i> <i>Middle</i> <i>Last</i> <i>Suffix</i>
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined Plurality: Birth Order: Medical Record No.:
		Date of Birth: (MM/DD/YYYY) <i>/ /</i> Time of Birth: (HH:MM) <i>: </i> <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 not born in this facility, please answer the following questions:					
		<table border="1"> <tr> <td>In what type of place was the infant born? <input type="checkbox"/> Freestanding Birth Center (regulated by DOH) <input type="checkbox"/> Home (intended) <input type="checkbox"/> Home (unintended) <input type="checkbox"/> Home (unknown intent) <input type="checkbox"/> Clinic / Doctor's Office (not regulated by DOH) <input type="checkbox"/> Other</td> <td>If New York State Birthing Center, enter its name:</td> </tr> <tr> <td></td> <td>In what county was the child born?</td> </tr> </table>	In what type of place was the infant born? <input type="checkbox"/> Freestanding Birth Center (regulated by DOH) <input type="checkbox"/> Home (intended) <input type="checkbox"/> Home (unintended) <input type="checkbox"/> Home (unknown intent) <input type="checkbox"/> Clinic / Doctor's Office (not regulated by DOH) <input type="checkbox"/> Other	If New York State Birthing Center, enter its name:		In what county was the child born?	
In what type of place was the infant born? <input type="checkbox"/> Freestanding Birth Center (regulated by DOH) <input type="checkbox"/> Home (intended) <input type="checkbox"/> Home (unintended) <input type="checkbox"/> Home (unknown intent) <input type="checkbox"/> Clinic / Doctor's Office (not regulated by DOH) <input type="checkbox"/> Other	If New York State Birthing Center, enter its name:						
	In what county was the child born?						
Birthplace		Institution					
		<table border="1"> <tr> <td>Site of Birth, If Other Type of Place:</td> <td>Street Address – if other than Hospital / Birthing Center:</td> </tr> <tr> <td colspan="2">If place of infant's birth was other than Hospital or Birthing Center: City, town or village where birth occurred:</td> </tr> <tr> <td></td> <td>Zip / Postal Code:</td> </tr> </table>	Site of Birth, If Other Type of Place:	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:		
Site of Birth, If Other Type of Place:	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:							
	Zip / Postal Code:						

Attendant	Attendant's Information:		
	License Number:	Name: <i>First</i> <i>Middle</i> <i>Last</i>	
Certifier	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		
	<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	Primary Payor for this Delivery: Select one: <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	
		<table border="1"> <tr> <td>If Medicaid is not the primary payor, is it a secondary payor for this delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>If the mother enrolled in an HMO or other managed care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	If Medicaid is not the primary payor, is it a secondary payor for this delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Medicaid is not the primary payor, is it a secondary payor for this delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If the mother enrolled in an HMO or other managed care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Infant					
Infant	If Multiple Births: Number of Live Births: _____		Number of Fetal Deaths: _____		
			Birth Weight: _____ grams _____ lbs. _____ oz.		
	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				
Birth Information	Select all that apply: <input type="checkbox"/> Rapid / Advanced Labor <input type="checkbox"/> Bleeding <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Severe pre-eclampsia <input type="checkbox"/> Woman Refused Transfer <input type="checkbox"/> Other <i>(specify)</i>				
	Infant Transferred: <input type="checkbox"/> Within 24 hrs <input type="checkbox"/> After 24 hrs. <input type="checkbox"/> Not transferred		NYS Hospital Infant Transferred To: _____		State/Terr./Province: _____
	Apgar Scores 1 minute: _____ 5 minutes: _____ 10 minutes: _____		Is the Infant Alive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred / Status Unknown		Clinical Estimate of Gestation: (Weeks) _____
Birth Information	How is infant being fed at discharge? (Select one) <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				Newborn Treatment Given: <input type="checkbox"/> Conjunctivitis only <input type="checkbox"/> Vitamin K only <input type="checkbox"/> Both <input type="checkbox"/> Neither
	Hepatitis B Inoculation				
Hepatitis B	Immunization Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date: (MM/DD/YYYY) _____ / _____ / _____		Immunoglobulin Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date: (MM/DD/YYYY) _____ / _____ / _____					
Abnormal Conditions of the Newborn	Abnormal Conditions of the Newborn: <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU Admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizures or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention)				

Congenital Anomalies					
Congenital Anomalies	<input type="checkbox"/> None of the listed <input type="checkbox"/> Unknown at this time Select all that apply		Diagnosed Prenatally? If Yes, please indicate all methods used:		
			QI		
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Anencephaly	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Meningomyelocele/Spina Bifida	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Cyanotic Congenital Heart Disease	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Congenital Diaphragmatic Hernia	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Yes No <input type="checkbox"/> <input type="checkbox"/>	Omphalocele	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown		

Congenital Anomalies

Congenital Anomalies	Select all that apply		Diagnosed Prenatally?	If Yes, please indicate all methods used:	QI
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Gastroschisis	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound	<input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Limb Reduction Defect	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound	<input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Cleft lip with or without Cleft Palate	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound	<input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Cleft Palate Alone	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound	<input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen	<input type="checkbox"/> CVS <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Other Chromosomal Disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen	<input type="checkbox"/> CVS <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Yes No <input type="checkbox"/> <input type="checkbox"/>	Hypospadias	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound	<input type="checkbox"/> Other <input type="checkbox"/> Unknown	

Labor & Delivery

Labor & Delivery	Mother Transferred in Antepartum: <input type="checkbox"/> Yes <input type="checkbox"/> No	NYS Facility Mother Transferred From:	State/Terr./Province:
	Mother's Weight at Delivery: <i>lbs.</i>		
Method of Delivery	Fetal Presentation: <i>(select one)</i> <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other		
	Route & Method: <i>(select one)</i> <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		
	Attempted Procedures: Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Trial Labor: If Cesarean section, was trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Indications for C-Section: QI <input type="checkbox"/> Unknown Select all that apply <input type="checkbox"/> Failure to progress <input type="checkbox"/> Malpresentation <input type="checkbox"/> Previous C-Section <input type="checkbox"/> Fetus at Risk / NFS <input type="checkbox"/> Maternal Condition – Not Pregnancy Related <input type="checkbox"/> Maternal Condition – Pregnancy Related <input type="checkbox"/> Refused VBAC <input type="checkbox"/> Elective <input type="checkbox"/> Other		

Labor & Delivery

Method of Delivery	<p>Indications for Vacuum:</p> <input type="checkbox"/> Unknown QI
	<p>Select all that apply</p> <input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Other
Method of Delivery	<p>Indications for Forceps:</p> <input type="checkbox"/> Unknown QI
	<p>Select all that apply</p> <input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Other
Labor	<p>Onset of Labor</p> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time
	<p>Select all that apply</p> <input type="checkbox"/> Prolonged Rupture of Membranes -- (12 or more hours) <input type="checkbox"/> Premature Rupture of Membranes -- (prior to labor) <input type="checkbox"/> Precipitous Labor -- (less than 3 hours) <input type="checkbox"/> Prolonged Labor (20 or more hours)
Characteristics	<p>Characteristics of Labor & Delivery</p> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time
	<p>Select all that apply</p> <input type="checkbox"/> Induction of Labor – AROM <input type="checkbox"/> Induction of Labor – Medicinal <input type="checkbox"/> Augmentation of Labor <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Meconium Staining <input type="checkbox"/> Fetal Intolerance <input type="checkbox"/> External Electronic Fetal Monitoring <input type="checkbox"/> Internal Electronic Fetal Monitoring
Maternal Morbidity	<p>Maternal Morbidity</p> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time
	<p>Select all that apply</p> <input type="checkbox"/> Maternal Transfusion <input type="checkbox"/> Perineal Laceration (3rd / 4th Degree) <input type="checkbox"/> Ruptured Uterus <input type="checkbox"/> Unplanned Hysterectomy <input type="checkbox"/> Admit to ICU <input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery <input type="checkbox"/> Postpartum transfer to a higher level of care QI
Anesthesia / Analgesia	<p>Anesthesia / Analgesia</p> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time
	<p>Select all that apply</p> <input type="checkbox"/> Epidural (Caudal) <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> General Inhalation <input type="checkbox"/> Paracervical <input type="checkbox"/> General Intravenous <input type="checkbox"/> Pudendal
	<p>Was an analgesic administered?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
Procedures	<p>Other Procedures Performed at Delivery</p> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time
	<p>Select all that apply</p> <input type="checkbox"/> Episiotomy and Repair <input type="checkbox"/> Sterilization

Mother

Medical Record Number:

Mother's Education: (select one)

- | | | |
|---|---|---|
| <input type="checkbox"/> 8 th grade or less | <input type="checkbox"/> Some college credit, but no degree | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> 9 th – 12 th 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:	Country of Birth, if not USA:
----------------	--------------------------------	-------------------------------

Hispanic Origin:

Select all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> No, not Spanish/Hispanic/Latina | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana | <input type="checkbox"/> Yes, Puerto Rican |
| <input type="checkbox"/> Yes, Cuban | <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latina | |

Specify:

Race:

Select all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Samoan | |

<input type="checkbox"/> American Indian or Alaska Native	Tribe:	<input type="text"/>
<input type="checkbox"/> Other Asian	Specify:	<input type="text"/>
<input type="checkbox"/> Other Pacific Islander	Specify:	<input type="text"/>
<input type="checkbox"/> Other	Specify:	<input type="text"/>

Residence Address

Street Address:			
State/Terr./Province:	County:	City, Town or Village:	
Zip/Postal Code:	Mother's Country of Residence, if not USA:	U.S./Canadian Phone Number: () -	

Mailing Address – Most Recent

Check here if the mailing address is the same as the residence address (otherwise enter information below)

Mailing Address:			
City, Town or Village:	State/Terr./Province:	Country, if not USA:	Zip/Postal Code:

Employment History

Employed while Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current / Most Recent Occupation:	Kind of Business / Industry:
Name of Company or Firm:	Address:	
City:	State/Terr./Province:	Zip / Postal Code:

Parents

Mother's Demographics

Mother's Demographics

Mother's Residence

Mother's Mailing Address

Employment

Father

Will the mother and father be executing an Acknowledgement of Paternity? Yes No Not required

Father's Name: *First* *Middle* *Last* *Suffix*

Social Security Number:

Demographics

Father's Date of Birth:
(MM/DD/YYYY)

/ /

Education: *(select one)*

- | | | |
|---|---|---|
| <input type="checkbox"/> 8 th grade or less | <input type="checkbox"/> Some college credit, but no degree | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> 9 th - 12 th 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:

Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> No, not Spanish/Hispanic/Latino | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano | <input type="checkbox"/> Yes, Puerto Rican |
| <input type="checkbox"/> Yes, Cuban | <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino | |

Specify:

Race:

Select all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian Indian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Samoan | |

American Indian or Alaska Native Tribe:

Other Asian

Specify:

Other Pacific Islander

Specify:

Other

Specify:

Residence Address

Check here if the father's residence address is the same as the mother's address
(otherwise enter information below)

Street Address:

City, Town or Village:

State / Territory / Province:

Father's Country of Residence, if not USA:

Zip / Postal Code:

Employment History

Current / Most Recent Occupation:

Kind of Business / Industry:

Name of Company or Firm:

Address:

City:

State / Territory / Province:

Zip / Postal Code:

Parents

Father's Demographics

Father's Residence

Employment

Prenatal History

Parents	Prenatal History	Did mother receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Prenatal Care Provider Type: <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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Key Pregnancy Dates (MM/DD/YYYY) Date of Last Menses: Estimated Due Date: Date of First Prenatal Visit: Date of Last Prenatal Visit: / / / / / / / / / / / /				
		Prenatal Visits Total Number of Prenatal Visits:				
Pregnancy History	Pregnancy History					
	Previous Live Births: Now Living Now Dead None or Number None or Number <input type="checkbox"/> <input type="checkbox"/>		Previous Spontaneous Terminations: Less than 20 Weeks 20 Weeks or More None or Number None or Number <input type="checkbox"/> <input type="checkbox"/>		Previous Induced Terminations: None or Number <input type="checkbox"/>	Total Prior Pregnancies: None or Number <input type="checkbox"/>
	First Live Birth: (MM / YYYY) / / /	Last Live Birth: (MM / YYYY) / / /	Last Other Pregnancy Outcome: (MM / YYYY) / / /	Prepregnancy Weight: lbs.	Height: ft. in.	

Prenatal Care

Parents	Other Risk Factors	Other Risk Factors				
		Smoking Before or During Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Number of Packs OR Cigarettes Smoked Per DAY 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			
Risk Factors	Risk Factors in this Pregnancy <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Prepregnancy Diabetes <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Prepregnancy Hypertension <input type="checkbox"/> Gestational hypertension <input type="checkbox"/> Other Serious Chronic Illnesses <input type="checkbox"/> Previous Preterm Births <input type="checkbox"/> Abruption Placenta <input type="checkbox"/> Eclampsia <input type="checkbox"/> Other Poor Pregnancy Outcomes <input type="checkbox"/> Prelabor Referred for High Risk Care <input type="checkbox"/> Other Vaginal Bleeding <input type="checkbox"/> Previous Cesarean Section, <input type="checkbox"/> Pregnancy resulted from infertility treatment (if yes, check all that apply) Number: <input style="width: 40px;" type="text"/> <input type="checkbox"/> Fertility-enhancing drugs, artificial or intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g. IVF, GIFT) Number of Embryos Implanted: (if applicable) <input style="width: 40px;" type="text"/> QI					
	Infections Present and/or Treated During Pregnancy <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes Simplex Virus (HSV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Rubella <input type="checkbox"/> Bacterial Vaginosis					

Prenatal Care

Other Risk	Other Risk Factors		
	Alcohol Consumed During This Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Drinks per Week:	Illegal Drugs Used During This Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetric Procedures	Obstetric Procedures <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Cervical Cerclage <input type="checkbox"/> Tocolysis <input type="checkbox"/> External Cephalic Version — <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> Fetal Genetic Testing QI		
	If woman was 35 or over, was fetal genetic testing offered? QI <input type="checkbox"/> Yes <input type="checkbox"/> No, Too Late <input type="checkbox"/> No, Other Reason		
	Serological Test for Syphilis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Test: (MM/DD/YYYY) / /	Reason, if No Test: <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

Parents	Survey of Mother (in hospital)	
	Did you receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If 'Yes' please answer question 1. Otherwise skip to question 2.)</i>	
	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"/>
	b. How drinking alcohol during your pregnancy could affect your baby?	<input type="checkbox"/> <input type="checkbox"/>
c. How using illegal drugs could affect your baby?	<input type="checkbox"/> <input type="checkbox"/>	
d. How long to wait before having another baby?	<input type="checkbox"/> <input type="checkbox"/>	
e. Birth control methods to use after your pregnancy?	<input type="checkbox"/> <input type="checkbox"/>	
f. What to do if your labor starts early?	<input type="checkbox"/> <input type="checkbox"/>	
g. How to keep from getting HIV (the virus that causes AIDS)?	<input type="checkbox"/> <input type="checkbox"/>	
h. Physical abuse to women by their husbands or partners?	<input type="checkbox"/> <input type="checkbox"/>	
2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities?	Times per week:	
3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. During your pregnancy, would you say that you were: <i>(select one)</i>		
<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?		
<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)	Chart Review (Prenatal and Medical)	
	1a. Copy of prenatal record in chart?	
	<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?	
	<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?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> No, Too Late		
1d. Was MSAFP / triple screen test done?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery?		
Admission and Discharge Information		
Mother		
Admission Date for Delivery (MM/DD/YYYY)	Discharge Date (MM/DD/YYYY)	
/ /	/ /	
Infant		
Discharge Date (MM/DD/YYYY)	<input type="checkbox"/> Discharged Home	
/ /	<input type="checkbox"/> Infant Still in Hospital	
	<input type="checkbox"/> Infant Transferred Out	
	<input type="checkbox"/> Infant Died at Birth Hospital	
	<input type="checkbox"/> Infant Discharged to Foster Care/Adoption	
	<input type="checkbox"/> Unknown	
Admission & Discharge		