

For each question indicate who is the source for this information.  
Use the Source Code Table placed on the right.

**H. PREGNANCY HISTORY**

Infant's last name   
First name

Source of information  
 BP  GP  AP  Ph  HR  O →

**1 Information about the infant's biological mother:**

First name  Last name   
 Middle name  Maiden name   
 Date of birth / /  SS# --  
Month Day Year

Current address:  
 Street  City  State  ZIP -  
City State

How long has the biological mother been a resident at this address?  Years and  Months Previous residency:   
City State

**Source Code Table**

- BP ..... Biological Mother/Father
- GP ..... Grandmother/Father
- AP ..... Adoptive or Foster Parents
- Ph ..... Physician
- HR ..... Health records
- O ..... Other (specify)

Source of information  
 BP  GP  AP  Ph  HR  O →

**2 When did the biological mother begin prenatal care?**

Weeks  No prenatal care  
 Months  Unknown } → Skip question **4** below

Source of information  
 BP  GP  AP  Ph  HR  O →

**3 Where did the biological mother receive prenatal care? (Please specify physician or other health care provider name and address)**

Physician/ Provider  Hospital/ Clinic  Phone   
 Address:  
 Street  City  State  ZIP -  
City State

Source of information  
 BP  GP  AP  Ph  HR  O →

**4 During her pregnancy with the infant did the biological mother have any complications?**

(e.g., high blood pressure, bleeding, gestational diabetes)  
 No  Yes → Specify

Source of information  
 BP  GP  AP  Ph  HR  O →

**5 Was the biological mother injured during her pregnancy with the infant?**

No  Yes → Specify

Source of information  
 BP  GP  AP  Ph  HR  O →

**6 How many pregnancies and live births has the biological mother had?**

Number of pregnancies  Number of live births

Source of information  
 BP  GP  AP  Ph  HR  O →

**7 During her pregnancy with the infant, which of the following did the biological mother use?**

	Unknown	No	Yes	Specify
a) Herbal remedies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	} → <input type="text"/>
b) Over the counter medications.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c) Prescription medications.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d) Cigarettes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> average number cigarettes per day
e) Alcoholic beverages.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> average number alcoholic drinks per day
f) More than 5 alcoholic drinks in one sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> number of times
g) Marijuana (grass, pot, weed, dope).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h) Cocaine (crack, rock, coke, crank, zip).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
i) Heroin (brown sugar, H Henry, horse, junk, smack).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
j) Methamphetamine (chalk, crystal, meth, quick).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
k) Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>

Section completed on / /  at  :  by

Where/How